Coventry University

DOCTOR OF PHILOSOPHY

The Contribution of the Core Professions to the IAPT High Intensity Role

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Award date:
2017

Awarding institution:
Coventry University

Link to publication

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The Contribution of the Core Professions to the IAPT High Intensity Role

By Matthew David Wilcockson

September 2017

A thesis submitted in partial fulfilment of the university's requirements for the Degree of Doctor of Philosophy in the subject of Psychology

Acknowledgements

I would like to give special thanks to Julie Wilcockson and Gail Steptoe-Warren for their wisdom and patience throughout this process. I would also like to thank David Hughes and Christine Grant for their supervision and support at various stages of this thesis

Abstract

The advent of Improving Access to Psychological Therapies (IAPT) and the agenda of evidence based therapies has fundamentally changed the landscape of the delivery of psychological therapies in the United Kingdom (UK), providing rapid access to therapies for people with common mental health problems (Clark, Layard, Smithies, Richards, Suckling and Wright 2009). The primary therapy presently being delivered is High Intensity Cognitive Behavioural Therapy (CBT) in the High Intensity format. Accreditation as a CBT therapist requires four year's professional training (one year as a CBT therapist and three years as a core professional (e.g. mental health nursing, social work, etc.) or demonstrably equivalent Knowledge, Skills and Attitudes (KSA) to that core profession) to provide a foundation in generic clinical skills. These different forms of core professional training are considered to meet equivalent minimum standards by the accrediting agency, the British Association for Behavioural and Cognitive Psychotherapy (BABCP), but they also have their own idiosyncrasies. If there are differences in clinical practice between the core professions, this has implications for the evidence base of CBT, which should be delivered homogenously, and also the training methods, which may need to be modified to account for the differing professional backgrounds.

The broad aim of this thesis is to explore how these different core professions transition to becoming CBT therapists, comparing initial skills at the start of training, describing the transition process, and describing how CBT is practiced post transition for each professional grouping.
To meet these aims and objectives, three phases of the present research are proposed:

1) Phase one: A quantitative study to compare the level of CBT skills in 12 domains of the Cognitive Therapy Scale (revised) (CTS-r) at the start of training in each core profession and a further study comparing self-and supervisor ratings in the same 12 domains.

2) Phase two: Aqualitative study, using reflective reports to explore how each core profession learns CBT.
3) Phase Three: A focus group with two professional groups to explore how different core professions practice CBT.

Results of the research found that

a. Students without a core profession, but equivalent experience (KSA) outperformed mental health nurses, counsellors and occupational therapists in a number of CTS-r domains and were equivalent in the remainder in both studies.
b. Mental health nurses and counsellors both learned through their existing skills (technical rationality and experience-as-client) respectively. Both groups resisted some aspect of practice initially and some of this was resolved through cognitive dissonance or behavioural reinforcement. There was less intra personal conflict for the KSA group due to less conflicting expectations. All groups adopted reflective practice.
c. Mental health nurses substituted nursing practice for CBT practice and there was some shame of their previous nursing practice. However when nursing added to the role (risk assessment, knowledge of healthcare systems) nursing practice was maintained – a "CBT-plus" approach. Counsellors retained some of their original identity and did not fully adopt CBT resulting in a complex mix of counselling, CBT, and the individual.

There are variations in initial skills, learning processes, and post qualification practice between the core professions. The non-professionalised group (KSA) exhibit higher levels of core skills and a smoother transition process compared with the core professions, contradicting conventional research that professionalization adds value. This has implications for the delivery of CBT according to the evidence base in practice, and the validity of aspects of the research underpinning it.

Recommendations to address training at the core professional and CBT level are made to ensure greater consistency in learning of CBT.

Ethics Phases 1 and 2

REGISTRY RESEARCH UNIT

ETHICS REVIEW FEEDBACK FORM

(Review feedback should be completed within 10 working days)

Name of applicant: Matthew Wilcockson.....

Faculty/School/Department: [Health and Life Sciences] HLS
Psychology .....

Research project title: The contribution of the different core professions to the IAPT High Intensity Role

Comments by the reviewer

1. Evaluation of the ethics of the proposal:
The study as described meets ethical and research governance requirements.

2. Evaluation of the participant information sheet and consent form:
The content of the participant information sheet and consent form are satisfactory, except that the participant information sheet requires a title on it, and both require a version number and date adding.

3. Recommendation:
(Please indicate as appropriate and advise on any conditions. If there any conditions, the applicant will be required to resubmit his/her application and this will be sent to the same reviewer).

	Approved - no conditions attached
X	Approved with minor conditions (no need to re-submit)
	Conditional upon the following – please use additional sheets if necessary (please re-submit application)
	Rejected for the following reason(s) – please use other side if necessary
	Not required

Name of reviewer: Anonymous .....

Date: 31/08/2012 .....

Ethics Phase 3

REGISTRY RESEARCH UNIT

ETHICS REVIEW FEEDBACK FORM

(Review feedback should be completed within 10 working days)

Name of applicant: Matthew Wilcockson.....

Faculty/School/Department: [Faculty of Health and Life Sciences]
Psychology .....

Research project title: The Contribution of the Core Professions to the IAPT High Intensity Role

Comments by the reviewer

4. Evaluation of the ethics of the proposal:	
5. Evaluation of the participant information sheet and consent form:	
6. Recommendation: (Please indicate as appropriate and advise on any conditions. If there any conditions, the applicant will be required to resubmit his/her application and this will be sent to the same reviewer).	
	Approved - no conditions attached
	Approved with minor conditions (no need to re-submit)
	Conditional upon the following – please use additional sheets if necessary (please re-submit application)
	Rejected for the following reason(s) – please use other side if necessary
X	Not required

Name of reviewer: Anonymous .....

Date: 19/07/2013 .....

v

List of Acronyms

ANOVA:…… Analysis of Variance

Asymp.Sign…… Asymptotic Significance

BABCP…….. British Association for Behavioural and Cognitive Psychotherapy

BACP……. British Association for Counselling and Psychotherapy

C…… Counselling

CBT…… Cognitive Behavioural Therapy

CCBT…….. Computerised Cognitive Behavioural Therapy

CTS…….. Cognitive Therapy Scale

CTS-r……Cognitive Therapy Scale (Revised)

DIT…… Dynamic Interpersonal Therapy

DPR……. Declarative, Procedural and Reflective

Ed……. Editor (s), edited by

Edn…….. Edition

GAD……..Generalised Anxiety Disorder

GMC…… General Medical Council

HCPC……Health and Care Professions Council

IAPT…… Improving Access to Psychological Therapies

IPT…… Inter Personal Therapy

K or KSA…… Knowledge, Skills and Attitudes

MANCOVA……. Multivariate Analysis of Covariance

N…… Nursing

NHS…….. National Health service (United Kingdom)

NMC…… Nursing and Midwifery Council

OCD……..Obsessive-Compulsive Disorder

p…… Probability

PWP…… Psychological Wellbeing Practitioner

PTSD……Post-Traumatic Stress Disorder

RMN..... Registered Mental (Health) Nurse

SD..... Standard Deviation

SP-SR..... Self-Practice and Self-Reflection

T..... Theoretical exploration

UK..... United Kingdom

UKCP..... United Kingdom Council for Psychotherapy

Z..... Number of standard deviations an element is from a mean.

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Chapter 1: Introduction

Chapter 1: Introduction

The advent of Improving Access to Psychological Therapies (IAPT) and the agenda of evidence based therapies has fundamentally changed the landscape of the delivery of psychological therapies in the United Kingdom (UK), providing rapid access to therapies for people with common mental health problems (Clark, Layard, Smithies, Richards, et al. 2009). IAPT was conceived following a commitment in the white paper "Our health, our care, our say" (Department of Health 2006), going live in a roll-out programme between 2008 and 2010. It was developed to "*offer patients a realistic and routine first line treatment for depression and anxiety disorders, combined where appropriate with medication*". (Department of Health 2011:5).

The most recent available figures suggest that there are approximately 3,600 IAPT high intensity therapists delivering mostly Cognitive Behavioural Therapy (CBT) to an estimated 75,000 primary care patients every year in the UK, (IAPT 2016), and there is provision for a further 2,500 over the next 5 years (NHS England and Health Education England 2016). The psychological therapy with the widest evidence base and availability is CBT, which is the exclusive focus of training for the first wave of IAPT trainees taking the Postgraduate Diploma in High Intensity Psychological interventions (Clark 2011).

CBT is an evidence-based therapy, with a literature search revealing over 6-10,000 academic papers on its research efficacy across a range of disorders, with over 800 of a discernible quality since 2000 (Hoffmann, Asaani, Yonk et al. 2012). These papers rely on adherence to a treatment protocol in order for the findings to be valid, and similar practice by the population of CBT therapists, numbering about 10,000 in the UK (Personal correspondence with the British Association of Behavioural and Cognitive Psychotherapies (BABCP), the principal accrediting organisation in the UK) for the findings to be generalisable.

Given that the evidence base for CBT requires relatively homogenous practice, it is important that the levels of generic CBT skills are broadly equivalent, that the learning and transition processes facilitate a relatively complete transition, and that the practice of each core profession is broadly in line with the evidence base.

The assumption of homogenous practice post qualification has long been taken for granted, and this is perhaps surprising given that the BABCP recognise "core professions" such as nursing, counselling and occupational therapy as providing the equivalent of 3 years training in generic CBT skills, with a further 1 year training required for provisional accreditation. This pattern of training is similar in a number of other countries.

This research proposes to address all of these issues. This research aims to compare initial levels of CBT skill in 4 core professions (nursing, counselling, occupational therapy and KSA (knowledge, skills and attitudes)) entering CBT training, examine the transitional and learning processes and outcomes for each core profession undertaking the Improving Access to Psychological Therapies (IAPT) training in CBT, and examine the practice of the different core professions post qualification.

Bearing in mind the scale of IAPT, and the overall budget of £170 million initially assigned to it (Clark et al. 2009) which remains ongoing and has further developed beyond primary care, it is recognised by the UK Department of Health as one of the most significant developments in the British National Health Service (NHS) for a generation (e.g. Byng and Cask 2009). Recruitment of a completely new workforce has been necessary, drawing together mental health professionals from a range of core professional backgrounds, especially from nursing and counselling, but also from a range of other healthcare professions (social work, occupational therapy and psychologists etc.). This has occurred because part of the basis for training in CBT is that a core profession and / or 3 years equivalent experience in generic clinical skills equivalent to a core profession is considered to be a mandatory requirement by the CBT accrediting organisation, the BABCP, before undertaking a CBT course of study, and accreditation is a requirement for the majority of IAPT jobs. Therefore relatively diverse

training for three out of four years of the required training is present, but homogeneity of CBT practice is expected as an end product (See Roth and Pilling 2008).

The BABCP also allows students with academic experience and healthcare experience, but not considered a core profession, to enter the IAPT training if their experience is deemed equivalent to a core profession. This group is often referred to as the Knowledge, Skills and Attitudes (KSA) group by the BABCP, due to the KSAs they are required to demonstrate in lieu of their core profession. Nursing, counselling and the KSA group (described as graduate mental health workers in the "New Ways of Working" (IAPT 2012)" document) are the largest groups for current trainees, followed by existing CBT therapists (not meeting IAPT competency criteria), clinical and counselling psychologists, and occupational therapists (IAPT 2012). Data provided by the BABCP (Table 1.1) shows percentages of core professions accredited with them.

:

Table 1.1: Approximate ratios of core professions accredited with the BABCP

Profession	Approximant percentage of accredited members (BABCP 2016)
Mental Health Nursing	25%
KSA Group	20%
Chartered Psychologist	15%
Counselling	10%
Occupational Therapy	5%
Social Work	5%
Other backgrounds (Psychiatry, art therapy, teaching)	20%

The broad aim of this thesis is to explore how these different core professions transition to becoming CBT therapists, comparing initial skills at the start of training, describing the transition process, and describing how CBT is practiced post transition for each professional grouping.

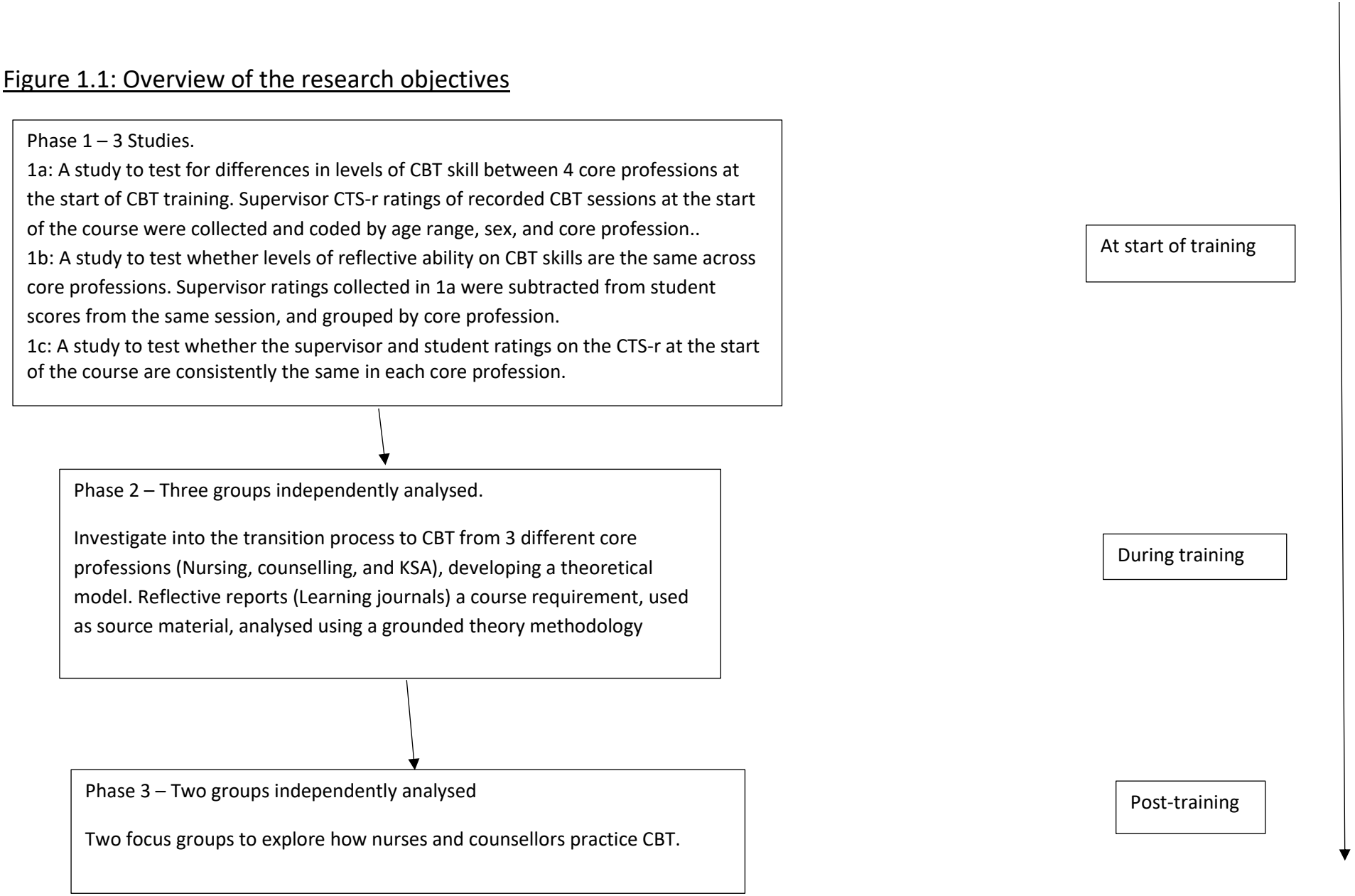
There have been a small number of attempts to understand the broad research aim within the literature. One doctorate thesis (Wills 2007) focused on individuals moving from other psychotherapies into CBT, however there have been significant developments in CBT since this point, from both a cultural and a political perspective, one of which is the development of IAPT. There are two studies from the nursing literature with similar objectives, one a single case study (Binnie 2008) and the other a retrospective study (Robinson, Kellett, King et al. 2012) – see 2.4.1 for a summary.

The author is aware of a number of studies related to the culture and practice of nursing and counselling, (See 2.4.1 and 2.4.2 respectively), which may be useful in highlighting some general differences between the professions, but there is very little written about CBT-specific domains, and also very little written about the KSA grouping.

Some research has been conducted on the process of learning CBT, e.g. Bennett-Levy (2006). Initially, validation of training programmes and demonstration of added value at a macro level pervaded the research (E.g. Westbrook, Sedgewick-Taylor, Bennett-Levy, et al. 2008), then an analysis of a range of micro skills and teaching processes such as formulation, role play, reflection, supervision, self-practice were evaluated (Bennett-Levy et a 2009, Jackman, Wood-Mitchell and James 2012). There is also a theoretical model of learning and acquiring competence in CBT (Bennett-Levy 2006) in existence. This model and the aforementioned research both treat the participants as a single grouping with no research looking at the impact of different professions entering the training in this respect being identified (personal correspondence with James Bennett-Levy, and Freda McManus, leading experts in CBT skills acquisition).

The present research differs from previous research in that it addresses the influence of the core professions on the IAPT high intensity role at the beginning, middle, and end of training. A brief summary of the research aims is provided below in Figure 1.1, and explored in greater detail in chapters 3, 4, and 5. The secondary aim of the research is, to assess the impact of the different core professions on the CBT identity and practice of the IAPT high intensity therapist. In order to meet the aims; the research involves three phases which have a number of objectives. To further clarify the research process, a GANTT chart is included in appendix 13.

Figure 1.1: Overview of the research objectives



Phase one: Assessment of core professional skills on entering IAPT (CBT) training. This phase of the research is divided into 3 objectives.

1a: **Objective: To assess whether there are differences between the core professions in 12 generic and CBT skills pertinent to CBT practice on entering CBT training**

These skills are rated by supervisors based on a student's clinical session as part of the course, using a validated measure, the CTS-r (Cognitive Therapy Scale Revised, see Appendix 2 for a summary of the skills assessed).

1b: **Objective: To assess for differences in the students' belief about their level of generic and CBT skills, between the core professions**. The accuracy, or consistency with supervisor's appraisal of the student's skill level, is obtained by subtracting the student's rating from the supervisors, according to the core profession.

1c: T**o assess whether supervisor and student assessments of the 12 generic and CBT skills are different in each core professional grouping**. The ratings of supervisor and student are collected separately, grouped by core profession, and analysed to assess whether the ratings of supervisor and supervisee are statistically different.

Phase two: Qualitative study to understand of the transition process in becoming an IAPT (CBT) therapist. This phase of the research has one objective:

> **To develop a theoretical understanding of how each core profession learns and transitions to CBT.**

This is achieved by conducting a (Glaserian) (Glaser 1992) grounded theory study on each professional grouping (nursing, counselling, KSA) using student reflective reports as source material.

Phase 3: A descriptive analysis of the practice of CBT in each core profession post training and qualification as a CBT (IAPT) therapist. This phase of the research has one objective:

1) **To establish how each core profession practices CBT as a high intensity therapist post training,**

This is achieved by undertaking two focus groups (nursing and counselling). These two groups were utilised as they had the most complexity and incompleteness in their transition to CBT.

The process of triangulation strengthens the research (See Figure 1.2 below). In social research, triangulation refers to the observation of the data from at least 2 different points including different sources, times, and methodological approaches (Flick 2004). Within this research, different data sources (Students and qualified therapists), methodologies (Grounded theory, Thematic Analysis, Quantitative), and data collection (Validated questionnaires, reflective reports (text) and focus groups) are all used

Triangulation is supported by Brewer and Hunter (2006), who argued that triangulation between qualitative and quantitative methods provide an effective means of assessing convergence, as well as expanding on divergences between the results. For example, the use of a quantitative measure (the Cognitive Therapy Scale (Revised) (CTS-r) may improve our understanding of competencies, and allow for an assessment of differences between professions (nursing, counselling, occupational therapy and KSA). The use of qualitative written material during the process of transition (Phase 2) allows the researcher to obtain a richer understanding of differences or similarities found within the CTS-r, and the focus group method post training (Phase 3) allow the researcher to verify the previous data using a different form of data collection, and data analysis, set within a different timeframe, obtaining a richer contextual understanding. Using a triangulation of both qualitative and quantitative data, according to Yin (1994), allows for generalisation of results, and can compensate for smaller group sizes.

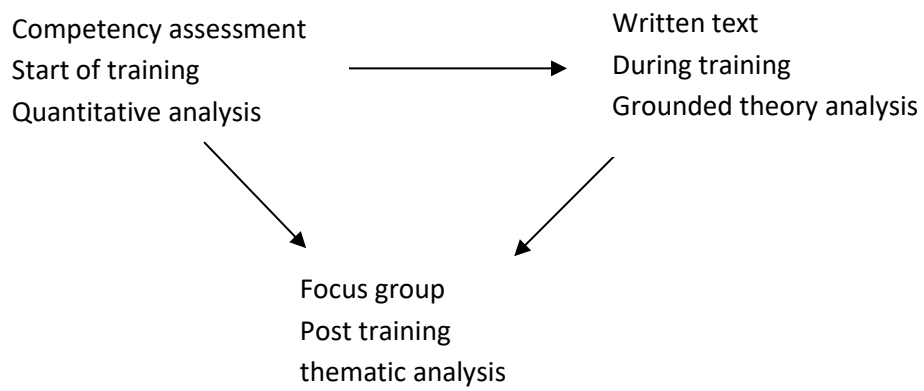


Figure 1.2 – Triangulation approach used to assess the contribution of the core professions to the IAPT high intensity therapist

1 1 Rationale for the research

The research on role transition largely focuses on the change in job roles within organisations rather than on the transition between professions (Ashforth 2000). These roles are often between different levels of seniority, not a change of profession as in the IAPT training. Furthermore, the change of profession involves the acquisition of additional academic and professional knowledge and skills beyond a traditional job role change, and existing studies (Croft, Currie and Lockett 2015a, Latack 1984) do not address this level of complexity or specificity in transition.

The evidence base for CBT is heavily dependent on the adherence to the treatment models according to the presenting disorders (See Rakovshik and McManus 2010), and this is the basis for the IAPT curriculum (Clark et al. 2009). There is a tendency for professionals to fall back on familiar practices when uncertain, such as medicalised approaches (Hamilton, Manias, Maude, et al. 2004). In spite of the need for adherence, three of the four years training required to be an accredited Cognitive Behavioural Therapist in IAPT have significant variance between the core professions, and perhaps in some cases core professional training conflicts with CBT principles (See 2.2). The author has not been able to identify any research that compares different professional groups transitioning to one group simultaneously. If pre-existing culture and practice of core professions does influence how and what is learned on the IAPT training course, therapeutic outcomes may not be maximised. The findings from the present research can assist planning of the training to ensure a greater convergence in students' practice, help overcome problems / barriers to learning, and also assist supervisors' awareness of potential "blind spots" in supervisees' development and practice.

The research in transition to IAPT is largely limited to a retrospective study (Robinson et al. 2012) and a single case retrospective descriptive study (Binnie 2008), both involving nurses. No attempts to address other core professions have been identified, and no quantitative attempts to address CBT skills levels in the different core professions has been identified, The use of learning journals, the

source material for phase 2 of the research, ensures data is obtained as close as possible to its occurrence, enhancing authenticity.

1.2 Original contribution to research

Given the gaps in the research identified above, the current research aims to ascertain whether the generic skills in CBT are equivalent among the core professions at the start of CBT (IAPT), as proposed by the BABCP. The author is not aware of any testing or questioning of this proposed equivalence in the literature in spite of it being the foundation (3 out of 4 years, or 75%) of total training for a high intensity therapist. Transition models have previously been tested in the context of job roles, but only in the context of unequal roles (such as promotions, Croft, Currie and Lockett 2015a). This research examines the transition between more equal roles in the context of core professions and CBT, and the relevance of the models of transition in this context.

The training process in IAPT assumes that similar methods and styles of teaching delivered to people of different core professional backgrounds will produce similar results. The present research aims to identify variant processes in transition and learning experienced by different core professions, and makes recommendations about facilitating this process to ensure a complete transition to IAPT. This study aims to identify how core professions practice CBT post training and whether this is different based on original core profession. No other studies exist that directly address this issue.

Overall, this research provides the first comprehensive attempt to consider how the process of previous training and experience impacts upon the practice of CBT, which has been previously assumed to make no meaningful difference.

1.3 The author's position within the research

The researcher is also a qualified CBT practitioner, albeit not via the IAPT training, having come through the core professional nursing route. Prior to being a CBT practitioner, the researcher's main area of experience was in acute and forensic mental health. The complexities of the forensic environment led him to acknowledge and adopt skills and attitudes necessary for working with difficult clients, and this encouraged him to use skills that, at the time, were on the fringes of CBT, such as managing resistance and using the therapeutic relationship as a therapeutic tool. These skills were not valued by the mainstream of CBT at the time. While identifying as a nurse, the researcher also identifies with trying to adapt CBT to incorporate a wider skill set than is traditionally used, some of which may conflict with traditional views of CBT, but incorporated into advanced practice, which appears to be an issue for counsellors too within the data.

The researcher has worked in a clinical psychology department for ten years without a clinical psychology qualification, and suspect that there may be parallel aspects of experience with the KSA group. The researcher acknowledges this as an area where personal experience could interfere with objectivity, both from a respect perspective and a parallel experience perspective, however, awareness and acknowledgement enables the researcher to verify the data for personal contamination. Confirmation with theory, previous research, and triangulation with other parts of the research also helps challenge any researcher bias.

It is of relevance that the researcher has been an occasional lecturer on the Coventry University IAPT course since its inception in 2009, and was himself a seconded clinical specialist within IAPT. In this regard the researcher "went through" some of the experiences described by the participants. It is of relevance also that there are a wide range of responses, and, having trained previously in CBT, the researcher believes his responses were generally different to those of the students during IAPT training, due to completing training about 10 years previously and having the benefit of experience in CBT.

The researcher recognises a personal interest in this study. This has developed out of an observation of different knowledge, skills, and attitudes among core professions undertaking CBT which appeared to be different, but was difficult to put into words. Thus there is also the danger of an "expectation effect". Regular supervision meetings discussing the data and the analysis process, maintaining a personal journal (Appendix 10), and being open about my position has helped manage this process.

1.4 Summary of Chapters

Chapter one provides an overview of the research, the rationale for conducting it and novel contribution to IAPT training and practice

Chapter two reviews relevant bodies of literature pertinent to the research. It firstly charts the development of CBT, and then identifies issues concerning its relationship with other professions. The chapter then evaluates literature regarding the conceptualisation of the core professions and CBT as entities, considering the notions of work cultures, professions, and groups, and identifies theory and research pertaining to cultural aspects of the core professions and CBT. The chapter then summarises the literature on learning and transition, the dynamic factors in the current research.

Chapter three describes the method, results and summary for the three studies comprising Phase 1 of the research.

Chapter four describes the method, results and summary for Phase 2 of the research with 3 independent groups (nursing, counselling, and KSA) each study offering a different theory of transition.

Chapter five describes the method, results and summary for phase 3 of the research, in 2 independent groups (nursing and counselling).

Chapter six synthesises and triangulates the data from the 3 studies and develops conclusions to the thesis.

Chapter 2 – Literature Review

Chapter 2. Literature review

The literature review seeks to provide a comprehensive understanding of the research and theories relating to transition between the core professions and CBT, and factors that might affect it. In respect of this, a summary of concepts including professions, and social groups are reviewed, focusing on factors that may reinforce group behaviour and inhibit transition. Also, in respect *to* the above question, research on the culture, affiliation, and practice of each individual core profession is also reviewed. The literature review then focuses on transitional processes, which is necessary to understand the characteristics of the process of moving between groups, and also factors assisting successful (or otherwise) transitions. Theory and research is drawn from transitional psychology, social psychology, occupational culture, cultural shifts, and cognitive dissonance. A theoretical model is presented, synthesising the most important findings as applicable to the current research. Finally, the literature provides an introduction to the process of learning CBT – the lens through which the core professions are viewed throughout the research, and an overview of learning frameworks.

An example of the terms used for the initial literature review are included in Appendix 1. Reading of standard texts on the subject contributed further material not available to the initial search, as did references from the texts of the initial search. A scan of abstracts of google scholar referencing key papers in the source material also a*i*ded further reading.

2.1: The development of CBT

Cognitive-Behavioural (sometimes Cognitive-Behaviour, or Cognitive) Therapy or CBT, is the most significant treatment available in IAPT (Clark 2011), and the subject of the training course under investigation in the current research. CBT is a collection of skills and techniques that seeks to use change in thinking and behaviour to influence the client's emotional state (Greenberger and Padesky

2008). Cognitive Therapy was developed independently by Ellis (1962) and Beck (1963, 1964) who described a lack of emphasis on the client's cognitions, or way of processing and interpreting information, as a primary influencing factor on the client's emotional state at that time.

The theoretical principles of Behavioural therapy were developed with Pavlov's (e.g. 1927) work on classical conditioning, and a number of contributors to operant conditioning (E.g. Mowrer 1947), laying a psychotherapeutic foundation of changing emotions through behavioural change. Behavioural therapy developed in the 1950's and 1960's partly as a reaction against the lack of empiricism in delivery and outcome in psychoanalysis, which largely held a monopoly on psychotherapy until that point.

Cognitive therapy rapidly developed an empirical stance and a focused treatment approach, which allied itself naturally with behavioural therapy (Hawton, Salkovskis, Kirk et al. 1989). This culminated in the UK with the formation of the professional organisation the British Association for Behavioural and Cognitive Psychotherapies (BABCP) in 1972. Some features consistently adhered to within the CBT approach include:

- Targets and use of measurement
- Adherence to evidence base
- Changing cognitions and behaviour in order to change emotions
- Formulation based treatment
- Collaboration
- A structured approach including agenda setting and homework
- Present focus

(Westbrook, Kennerley and Kirk 2011 Grant, Mills, Mulhern et al. 2010, Hawton et al. 1989)

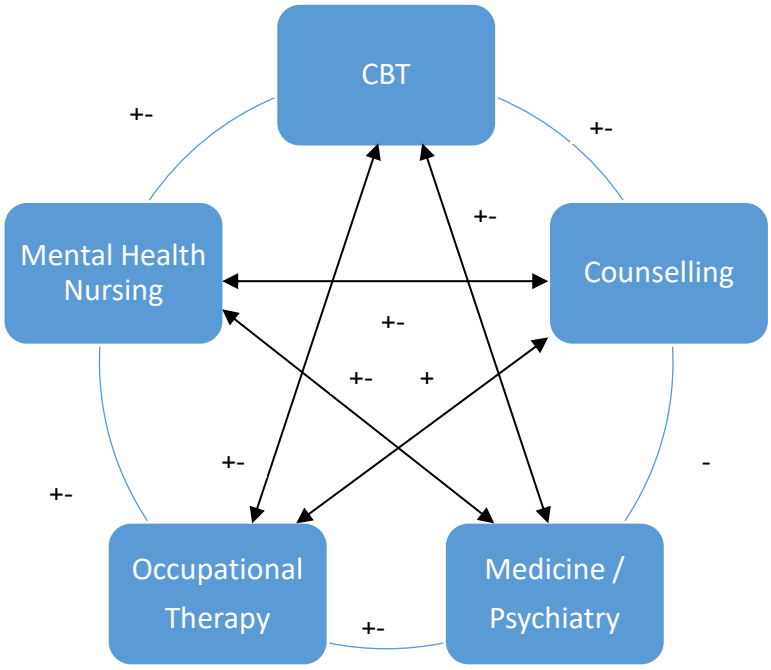
Since that time, CBT has expanded to include a broad range of approaches and therapeutic stances within the above framework, and the evidence base has expanded to include a wide range of disorders. The evidence base does not apply to CBT per se, but specified CBT approaches to each disorder (see 2.2. below). There was also a democratisation of the delivery of CBT, delivered by nurses and other allied healthcare professionals. In 2008 in the UK, CBT became the largest therapeutic component of IAPT, covering CBT models for seven of the most common primary care diagnoses at high intensity level, but also delivered at a more basic, educational and protocol-driven level where appropriate, making clients only seen for the level and time necessary, improving the financial viability of CBT. CBT continues to be delivered across differing levels of need and disorders, using differing methods and with some cultural variations.

2.2: CBT's Relationship with other therapies, core professions, and medicine

Although there are a large number of therapies practiced, most UK therapists identify as practicing CBT, psychodynamic, or humanistic as their main therapeutic approaches. Compared with these and other psychotherapies, CBT has taken an *empirical* stance, emphasising the importance of evidence-based research; developed theoretical models to explain the features and maintenance processes for a range of disorders, and has tested a range of approaches with different disorders in controlled trials, in order to establish an evidence base (Hawton et al. 1989). A number of other therapies are now starting to adopt this approach, such as Interpersonal Therapy (IPT) (Frank and Levenson 2010) which places more emphasis on the relationships than CBT**.** In the primary care context, CBT treatment and theory varies according to the condition treated, and disorder specific models and treatment approaches are used based on evidence for specific phobias (e.g. Ost, Salkovskis and Hellstrom 1993), depression (Teasdale, Fennell, Hibbert et al. 1984, Beck, Hollon, Young et al. 1985), panic disorder (Barlow, Gorman, Shear et al. 2000) social phobia (Heimberg, Liebowitz, Hope et al 1998, Clark and Wells 1995) generalised anxiety disorder (GAD) (Borkovec and Ruscio 2001), post-

traumatic stress disorder (PTSD) (Foa, Hembree, Cahill et al. 2005) and obsessive-compulsive disorder (OCD) (Freeston, Ladouceur Gagnon et al. 1997). These models and treatment approaches also form the learning competencies for the course under scrutiny in this research (Roth and Pilling 2008) and form the mainstay of primary care treatment. Homogeneity is required to maintain the evidence base (Waller 2009), which is dependent on consistent and reliable replication of established protocols. Different expectations and interpretations of CBT from core professional training may compromise this homogeneity.

Figure 2.1: The relationship between the core professions, medicine and CBT



Legend:

+ Features, key practitioners in common

- Areas of conflict present

The relationship between the core professions, CBT and medicine is undoubtedly complex (see Figure 2.1), incorporating both areas in common and areas where there is conflict of ideology and practice. For example, because of the link to diagnoses, CBT has a significant historical relationship with psychiatry. Disorder specific models and approaches remain central to CBT practice, and key figures within the CBT profession such as Aaron Beck and David M Clark are also psychiatrists. This could explain some negative responses to it being an "establishment approach" from traditionally "anti-psychiatry" professions such as counselling (House 2012), social work and, to a lesser extent, occupational therapy**.** An increasing emphasis on formulation within CBT has necessitated a more individualised approach to practice, although this has more recently brought it into conflict with a symptom-based medical model approach, for example emphasising maintenance cycles over symptoms when treating diagnostic categories, although the medical influence remains strong.

Training in Cognitive and Behavioural Therapy thus remained fragmented throughout the early stages of its development, sometimes along core professional lines. For example, nurse behavioural therapy training and third sector training had a high emphasis on technique without an understanding of, or a belief in the necessity of, the therapeutic relationship, (Gournay, Denford, Parr et al. 2000). This led to different versions of CBT existing in parallel between the 1970's and the 1990's.

These different versions of CBT were often heavily influenced by one profession - for example, behaviour therapy training for nurses placed a strong emphasis on measurement and behaviour change but not the therapeutic relationship (Gournay 2000). In counselling training, basic CBT techniques were often taught in the wider context of the humanist approach (e.g. Trower, Jones, Dryden et al. 2011) and, in clinical psychology, CBT techniques were often taught parallel with other models (particularly psychodynamic, but often dependent on local expertise in different models), leading many students to adopt an eclectic or integrated approach.

However, within humanistic counselling and psychotherapy it is the therapeutic relationship *that* is seen as central, and the main mechanism of change (House 2011). This is perceived as being in conflict with CBT by many counsellors, who believe CBT does not adequately value the therapeutic relationship (e.g. Jenkins 1999). Humanist counsellors also criticise other features such as neglecting empathy, treating the problems superficially, taking an overly rigid approach, emphasising the educational aspects of the problem, or neglecting the role of emotions (Sudak, Beck and Wright 2003, Mollon 2010). Although some features of humanism have been integrated into CBT (e.g. appropriate use of empathy, Gilbert and Leahy 2007), there are still significant differences in emphasis in the therapeutic relationship between them. This is important as humanism is probably the most significant theoretical influence on the counselling profession, and this conflict may be brought into CBT training by counsellors. Humanism, with its person-centred focus, has also significantly influenced other professions not traditionally allied with psychiatry; for example; patient centred advocacy in social work.

In response to the above criticism, it is worth noting that the relationship between CBT and the therapeutic relationship is complex. Beck, the originator of cognitive therapy, was a psychodynamic therapist and he assumed, for example, that the use of the therapeutic relationship and empathy were part of the process, although this was not always explicit (Beck 1976:221).

CBT has now become a psychotherapy that incorporates different historical perspectives and different philosophical standpoints (e.g. rationalism and constructivism are both present), different levels of delivery (and a range of different models for each of these levels) and a very wide variety of techniques. As no organisation or professional has “owned” CBT in the same way as occurs in some other therapies (such as gestalt, psychodynamic), the range of new techniques (e.g. Acceptance and Commitment therapy, Metacognitive therapy) continues to grow unregulated.

CBT adherents have criticised other psychotherapies for being unnecessarily complex and only applicable to the most severe cases (Bower and Gilbody 2005), and that it is unethical not to

intervene at the minimum appropriate level of therapeutic need (Lovell and Richards 2000). This has led to different forms of the therapy being developed for different levels of severity over the last 10 years, culminating in the development of "stepped care", which is one of the cornerstones of IAPT (Richards, Bower, Pagel et al. 2012), see Figure 2.2. Clients entering level 1 care normally receive medication, watchful waiting (i.e. to see if clients recover naturally / and do not deteriorate) or straightforward advice provided in the General Practitioner (GP) surgery. Level 4 is generally of a complex or severe nature that would generally prohibit IAPT treatment, and this is not covered in the training (e.g. developmental trauma). Levels 2 and 3 are covered in IAPT, and this study will focus on the level 3, or high intensity therapist, who will mostly be providing individual CBT therapy for clients with moderate to severe depression and anxiety disorders. Level 2, covering manualised approaches, support for Computerised CBT, etc. does not have established measures, does not have accreditation requirements, and therefore does not have core professional entry requirements to the profession.

Figure 2.2 – The stepped care model

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From Stanton, Whelan and Surandranathan (2013)

Having briefly addressed the history and placed the development of CBT in its context, attention will now be given to CBT training. The extent of CBT training has historically been broad, being taught in clinical and counselling psychology courses, as a top-up to nurse training and as generic diplomas

(healthcare studies, integrative psychotherapy, etc.). In spite of CBT being a consistent feature across a range of courses, there has only recently *been* research into effectiveness of CBT clinical training from a macro perspective (e.g. Westbrook, et al. 2008, Bennett-Levy, McManus, and Westling et al. 2009). By contrast there are comparatively low levels of research into micro-teaching skills, existing knowledge and skills, self-reflective skills, and application of skills post training (e.g. reflection, Bennett-levy McManus, Westling et al. 2009, formulation, Jackman, Wood-Mitchell and James 2014).

Accreditation as a CBT therapist typically requires the equivalent of five years training, of which two of these are normally at a CBT postgraduate diploma level and the remaining are accounted for by a "core profession" such as nursing, counselling, social work or psychology, or the equivalent in prior experience (KSA). These two years are condensed into one on the IAPT CBT training. CBT is highly unusual in professional training in that the majority of the academic requirements are based on core professional trainings which lack homogeneity, allowing for considerable diversity in the way that its core skills are learned, which may impact on the transition and practice of CBT. Other factors impacting on transition include professional and group identity.

2.3: Factors contributing to core professional and group identity

There are many factors that may contribute or hinder professional and group identity, as shown in Figure 2.3 below. In reviewing the factors that impact on professional and group identity, the following psychological theories and concepts will be considered: learning theories, group behaviour and interaction, behaviour and attitude change. These are categorised into professions and professionalism, and group identity.

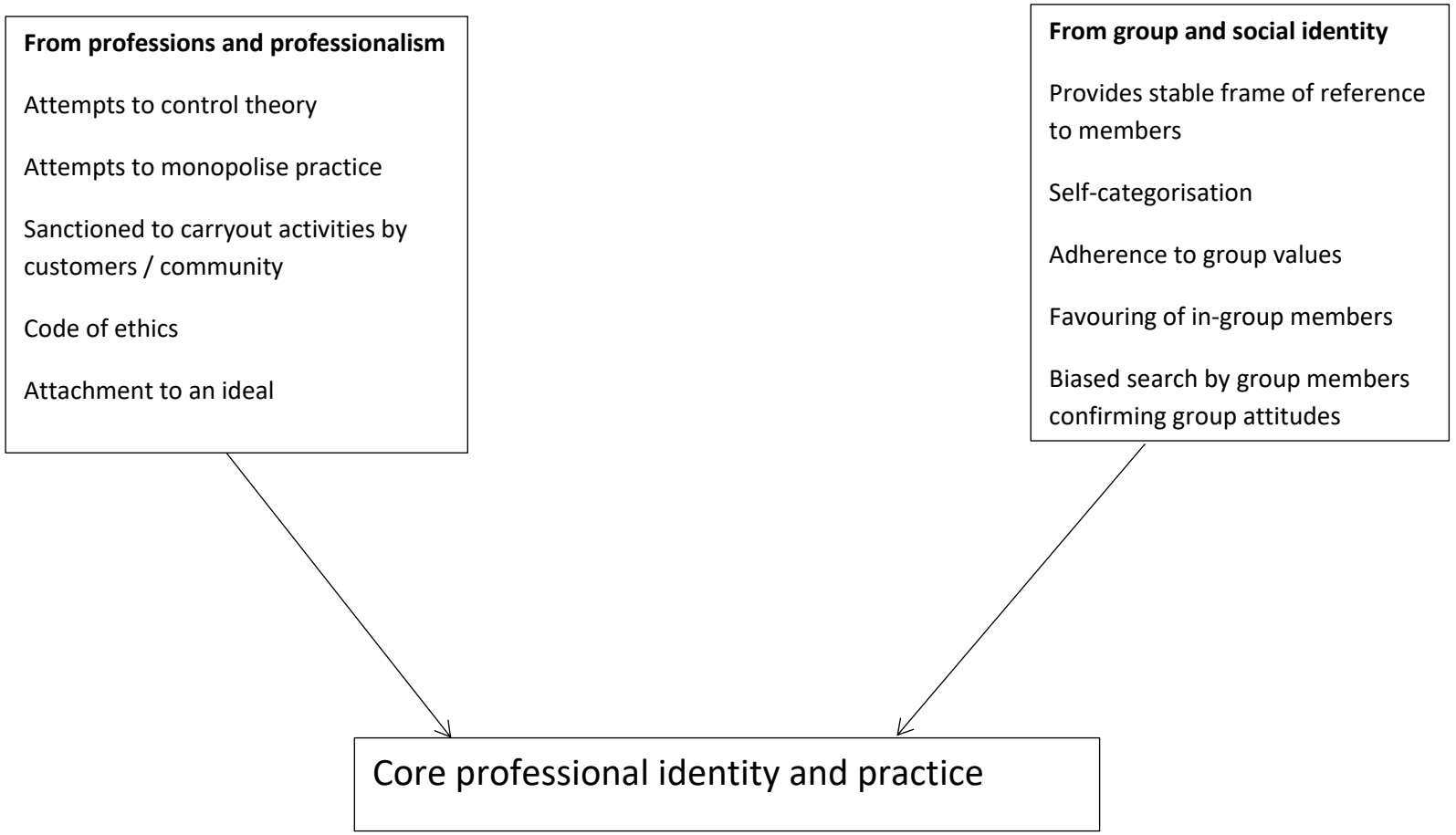

Figure 2.3: Factors contributing to core professional practice according to the literature

2.3.1: Professions and professionalism

Historically, a profession has been characterised by a body of theory, authority to conduct activities recognised by customers, sanction of this authority by a broader community, a code of ethics, and a distinct culture (values, norms and symbols) (Greenwood 1962). In the professional groups being studied in the current research (nursing, counselling, KSA, occupational therapy) are most obviously categorised according to their qualifications and registration. This is due to the fact that the professional groupings of the students entering the CBT profession represent at least a degree of cultural distinctiveness, which could influence the learning and practice of CBT. If students do indeed identify with and practice according to their current profession at the time of entry to CBT, it is important to consider the relevance of professionalisation on their CBT learning and skills development.

Friedson (1994) notes that the concepts and debates in the professionalism literature are clouded by unstated assumptions and incomplete usages, often expressed from the perspective of the profession themselves as a form of marketing (Ozga 1995) or by management trying to define the professions remit and responsibilities, neither of which are value free. Therefore, critical attention needs to be paid to any research undertaken from the perspective of, or on behalf of, the profession itself. This study avoids the lay use of the term profession (i.e. an identifiable trained group of workers) because, even though this description may be superficially accurate, the description lacks any detailed conceptual definition including sufficient academic rigour (e.g. overlaps with “trade”) and no research surrounding it. It is critical that professional roles, and the process of changing them, are viewed not just at the individual level, but also at the level of the professional groupings themselves. Professions may become compromised where boundaries are not maintained, and competition may come from professions with knowledge overlap (nurses and doctors, nurses and occupational therapists), or from the unskilled sector (e.g. healthcare assistants, Baverman 1974), who are usually much cheaper to employ.

The original perspective on professions as groups took the view that they generally function to benefit the public by preserving standards, enforcing the correct use of knowledge and skills by regulating ethical practice and maintaining high entry standards (e.g. Parsons 1939), and research in this area has largely focused on defining the "essence" of a profession (Summarised in Friedson 1994). Over the last 40 years there has been more of an acknowledgement of self–interest of the grouping (e.g. Macdonald 1995) including restricting entry, often setting academic requirements and theoretical frameworks higher than necessary to carry out the role. This restricts supply of those professionals and enables the profession to maintain a high price for their services.

Although consumerism and managerialism have eroded professionalism, especially via standardisation, a culture of mistrust, and a pressure to reduce costs (Friedson 2001), there is little evidence that professional influence has weakened (e.g. Hotho 1998) although resistance versus accommodation of management agendas remains an ongoing issue (Forbes and Prime 1999), and there has been some accommodation of management and consumer agendas by professions. Of course, just because management are keen to downplay professional conflicts with its agendas, it doesn't mean that such conflicts do not exist (Cameron 2011). Preservation of a profession typically occurs at its boundaries, where strategies are applied to maintain the status and identity of the profession. When circumstances affect the boundaries, professions either try and protect them, reject them, lay claim to new areas of knowledge, or a combination of all three (Fournier 2000). This revises boundaries to fit the new context and gives credence to the revised identity (Caglio 2003).

Attempts have been made to re-define professionalism in the light of the fact that it continues to exist in spite of many central tenets being broken (e.g. Friedson 2001). Certainly, at a global level, there is a weakened ability to influence policy issues and, at an individual practice level, managers may have more influence than professional bodies - autonomy has been replaced by accountability (Hoyle and Wallace 2005). Evans (2008) suggests that professional culture makes up most of what is considered to be professionalism, identified by Friedson (1994) as ideology, special institutions, and

homogeneity of values and viewpoints. Attachment to a transcendent value (e.g. nurses being "caring", doctors "doing good/doing no harm") is more important than the functional value of technical knowledge (Friedson 2001). Professional culture may evolve when formal arrangements are disallowed; Salhani and Coulter (2009) observed in nursing that formal arrangements have been replaced by informal arrangements and alliances – for example, the absence of a "professional lead" in, say, nursing may lead to informal arrangements bypassing formal management structures (such as informal "supervision" and support*)*.

Although there are a number of problems with the idea of "core professions" meeting the criteria for a profession, there are a number of reasons to suggest that core professions for CBT possess many features in common (risk assessment, mental health and service based knowledge, etc.) but also have a stable distinctiveness to each one. This largely occurs through training, and with reinforcement of practices by senior and prototypical members, see 1.5-1.8.

In summary, the notion of a professional grouping is attractive, but the core professional groups described in this research do not meet the traditional criteria for a profession in terms, in particular, of a body of knowledge or monopolisability. In spite of this lack of ability to implement ideal practice, professions appear to continue to have a strong influence over members' values and ideals, and also over the accountability of their practice. Although inappropriate as a definition, concepts from the professionalism literature contribute significantly to the research in areas such as attachment to values, performance of rituals, self-marketing, etc. We will now consider whether the broader concept of (social) group fulfils this definition.

2.3.*2:* Group and Social identity: Attitudes, Behaviour and group reinforcement

The notion of a group identity and practice, although a much more general concept than culture or profession, has appeal due to its independence. Organisational culture relies on affiliation to an

organisation, whereas core health professions, although commonly associated with the National Health Service in the UK, may belong to a range of organisational cultures or practice independently. In the current context of "Any Qualified Provider", (NHS Confederation 2012) where a range of private organisations are able to bid to provide NHS services, a range of different organisations exist within the NHS. The current research study is interested in the core professions attitudes and practice across, and in a broader context than, any individual organisation within which they may work. The concept of a group is sufficiently flexible to accommodate a clearer definition and greater cultural independence.

A further advantage of group / group identity as the framework for the measured variable is that Social Identity Theories move beyond the definition of a group, recognising that the entity only exists to the extent to which it is identified at the individual level (Moss 2008) and the emphasis and methodology of this *research* concerns individual experiences of group affiliation and transition to the extent that it affects CBT adherence and learning. Social identity suggests that people have an individual and collective identity (Tajfel 1974) and the collective identity contains information about the groups to which they belong, the extent to which they identify with this group, and the relative status and characteristics of the group (Tajfel and Turner 1986, Moss 2008).

Membership of groups has known benefits in terms of strengthening an ego defensive function of attitudes and enhancing the individual's experience and expression of belonging (Oakes, Haslam and Turner 1994), and may also fulfil many individuals' needs to be different at the same time. An example of the latter may be an individual providing a unique contribution which may only be appreciated by a professional group, (Hornsey and Jetten 2004). The relationship benefits attained from group members when compared with outsiders are well researched (See Abrams and Hogg 2001). Subjective Uncertainty Reduction Theory (Hogg 2004) postulates that people need and desire predictable information about others prior to communicating with them, and also need clear

expressed self-concepts. Voluntary self-categorisation into a group reduces uncertainty and enhances predictability of one's own self-concept.

Heck (1990) suggests further that identity within a professional group provides a stable frame of reference and helps people make sense of their lives in addition to providing a sense of belonging. If this is true, it may be expected that the effects of change between groups would be greater as the change would fundamentally affect the student's stable identity and self-concept. Expression of the groups' norms may fluctuate, but are generally higher when individuals perceive themselves to be representing that group or profession (Kvarnstrom 2008). Therefore: similarity of group fit with self-concept, status of the group, and the role of the group, all affect identity, and the relative influence of the core professions versus CBT would be expected to be influential in determining which group is most influential where there is conflict.

Reid and Hogg (2005) argue that, within groups, individuals search for and identify common beliefs, attitudes, feelings, and behaviours which they call prototypes, which help distinguish the "in" group from other groups. People voluntarily "self-categorise" (e.g. Arsenal fan, liberal) as a way of enhancing self-directed attributes towards themselves. According to self-categorisation theory, when identity is strong, depersonalisation occurs to the extent that all people are viewed not as individuals, but in terms of group identity and role, and can be considered interchangeable (Turner, Hogg, Oakes et al. 1987). The individual-group continuum of identity has been questioned by some studies (e.g. Swann, Gomez, Seyle et al. 2009) which suggest that at least some individuals demonstrate a merging of complying with group norms and individualistic behaviour, often developing and protecting the group. Group members have considerably higher identification and adherence to group norms when it is perceived to be under threat (Mullin and Hogg 1999, Van Knippenberg and Wilke 1992). According to this research, it would be expected that there may be some resistance to CBT if the values conflict with the core profession generating complex transition processes and complex post-transitional roles.

Not all groups focus primarily on individual adherence to group values. Some groups rely on a perceived threat as part of group culture and norms in order to preserve values and adherence, especially when competition for an area of identification is high (Macgregor, Reeshma and So-Jin 2008), usually by social creativity (emphasising the groups strengths) or social conflict (undermining of other groups) (Haslam and Platow 2001). Where social conflict is high in core professions, CBT may be conceptualised as an out-group.

Gaertner and Dovido (2014) argue in their In-group Identity Model that the reinforcement of the group occurs by favouring the in-group members rather than denigrating the outgroup members under most circumstances**.** This theory would suggest that if CBT conflicts with a core profession or a value from that profession, that the core professional value would be promoted rather than the CBT value rejected. The research is unclear in this area as the theory was not initially applied across a wide range of groups, although one study suggests some support for the principles of the model with healthcare assistants (Lloyd, Schnieder, Scales, Bailey, et al. 2011).

Individuals select social groups on the basis of personal attitudes which are "enduring systems of positive and negative evaluations, emotional feelings or action tendencies with respect to the individuals social world" (Ajzen 1985). Identities people choose on the basis of personality (E.g. benevolence, hedonism, stimulation, security, tradition, universality, power, self-direction, and security, Schwartz 1992) may have a bearing on professional membership according to some commentaries (Smith, Murphy and Coats 1999) but the area is largely un-researched. In *the current research*, if core professionals adopt this self-selecting group process then *it* would *be* expect*ed that* each core profession display*s* a tendency towards specific personality characteristics. These characteristics become a part of and reinforce the group attitude.

Reinforcement of group attitudes and behaviour is highest when a group has a strong cultural identity or is perceived as influential (Van Zomeran, Leach, and Spears 2010), if the individual is a high identifier with the group, or the group has impermeable boundaries to entry (Branscombe,

Ellemers, Spears et al. 1999). It may also be sustained by the individual's processes of attention and recall. Kunda (1990) argues that when individuals are motivated to hold an attitude, their cognitive processing and memory search is heavily determined by that motivation. Counter-arguments are not found, even if they are more prevalent, and information supporting the information may be amplified (Santioso, Kunda, and Fong 1990). Steele (1988) further asserts that a motivation to have an attitude that has a non-aversive consequence to an action leads to a biased memory search for information supporting that attitude. However, although there is a movement from the original attitude, the change does not typically conform all the way to full consistency with the motivation – some aspects of the old attitude are often integrated into the new attitude (E.g. not formally undertaking secondary care risk assessments in the new role, but maintaining a hypervigilance for risk). The extent to which individuals are aware of their social identity at any one point in time can dramatically alter behaviours towards the in-group (Tajfel 1972).

Social identity is known to be multidirectional (Ellemers, Van Knippenberg and Wilke 1990), for example, being American, Christian, and a football fan. Little research has been conducted into which factors take priority when these values have some conflict and some resonance with others (e.g. American, atheist, football fan). If core professional values conflict with IAPT / CBT, it is important to know how such values are resolved and in which direction.

It has been observed in this section that the professional groupings used within this research have weak policy and practice influence, and perhaps also less ability to enforce behaviour than managers within the NHS. However, in spite of this, identification and practice adherence remain comparatively robust. This has prompted sociologists to consider re-defining professionalism (Friedson 2001), key principles no longer apply, and ideas from social psychology, (such as social identity at an individual level, and group reinforcement at an individual and group level), provide useful frameworks in starting to explain the continuing relevance of professional cultures in the NHS

workplace. Now an understanding of group conceptualisation has been undertaken, research on cultures within the individual core professions will be addressed.

2.*4:* Research on attitudes and practice in each different core profession

In this section, an overview will be conducted concerning the evidence of the constitution of the professional and work cultures of the three main "core professions" in IAPT Therapists, and a brief review of occupational therapy. Similarities and differences will be highlighted between the beliefs of the individuals/profession, and their practice, and between the culture and practice of the core professions, and CBT. It needs to be borne in mind from studies asking professionals about their practice that language can be used as a form of social action to reinforce the professional ideal (Potter and Edwards 2001), and the research needs to be considered in the context of this.

At the time of writing, the coherence of each core profession as a distinct concept is not clear. Consideration will be given to cultural overlap between core professions, and also to the role of potential sub-cultures (such as between hospital and community based members of a profession, where literature exists) which, although may have many characteristics of the dominant grouping, may also have values that conflict, such as different attitudes towards medication among nurse prescribers. Different subcultures may have sharply different attitudes and practices from each other (e.g. different psychotherapeutic traditions).

2.4.1: Mental Health Nursing

The first core profession to be described and critiqued is the literature on mental health nursing (hereafter nursing) culture. As previously described, a core professional grouping is defined in terms of its behaviour and practice. Research in both of these areas will be considered. Attempts are made

to observe the motivating factors in expressed values, and conflicts in observed practice. There is an acknowledgement by some researchers that obtaining honesty in endorsements is a complex process, and it can be difficult to know if and when it has been honestly obtained (e.g. Brown 2000). Consideration will also be given as to whether inpatient and outpatient nursing are distinct subcultures. The students in all parts of the research are drawn from both groups.

There is some limited research of reasonable quality on mental health nursing culture and practice as assessed by academic judgements of quality, (e.g. Shenton 2014). In particular, "opinion pieces"; expressing idealised views on the subject by nursing academics which lack academic rigour, are commonplace. These pieces are generally excluded unless backed up by research, add originality to the debate or offer a theoretical critique.

The image of nursing in the mental health field is one of paradoxes. The Nursing and Midwifery Council (NMC)'s view of the profession appears to be increasingly a psychotherapeutic one, descriptors including:

> "This field is distinctive because its core is about the professional relationships nurses form with the people they work with. It is also about mental health nurses' ability to use their own thoughts and experiences - their 'self' - when working with people" and;
>
> "They use a range of relationship building and communication skills to work alongside people to support them in their recovery. This includes an ability to offer specific interventions, such as psychological therapies, family therapies, and other relationship and communication-based group and individual interventions". (Nursing and Midwifery Council 2010).

In this public projection, there is very little emphasis on procedural aspects of medicine that have historically characterised the profession. This projection appears to be adopted by nursing academics, who act as supporters of this image through idealised articles on subjects such as reflective practice and clinical supervision, (e.g. Parish 2010).The majority of the research is conducted on experienced practitioners, where length of time since qualification is made explicit. Those who are in a group for longer tend to become more consistent with the expected practices

over time in order to avoid conflict (Terry and Hogg 1999), which may distort the research towards emphasising features consistent with this.

The above view of nursing is at least partly reinforced by mental health nurses in clinical practice. Peck and Norman's (1999) qualitative research encouraged professional groupings in community teams to create a written dialogue of their roles, responsibilities, and professional identity of their own profession. This dialogue was then shown to other participating teams (psychiatry, psychology, occupational therapy, social worker, housing workers, and support workers) who were allowed to respond. The aim of the study was to discover some of the sources of difficulty in inter-professional collaboration. Because of the relatively small numbers in some professions (<5), the validity of some of the detail may have limitations; and as the professionals work in the same team, that team may have its own culture and professional relationship patterns.

The nurse's story in Peck and Norman (1999) is told in a context of therapeutic engagement with patients, such as

> "Nurses are close to patients"
>
> "Rather at the heart is the skills required by nurses to establish and maintain human contact with patients"
>
> "Interpersonal skills are highly valued by nurses"

However there appears to be a degree of embarrassment about these skills as core skills, and at a lack of a knowledge and skills base in their profession:

> "It is easy to overlook these skills and values and to de-value nursing by thinking "anyone could do it"" (Clinical Psychologist)

The response of the other professions reflects nursing practice rather than ideal professional projection. Some professionals pick up on the fact that nurses are embarrassed about their actual practice, and don't value it. The embarrassment at the ideal may be one factor in why it is only

implemented in a limited way in practice. Some other reasons why this occurs, according to Gijbels (1995:461) are:

> "Ideological differences, interprofessional and intraprofessional conflicts, administrative duties, bureaucratic constraints, organisational structures, personal abilities and unwillingness, low status, environmental unsustainability, and managerial pressures".

Theoretically, nursing is informed by both nursing (I.e. the caring relationship) and medical models, and these are not easy to reconcile (Hamilton et al. 2004). It has been noted that generalised self-portraits of the profession emphasise the caring relationship. However, when asked to emphasise or defend their skills, medical aspects with a technique based emphasis may also be communicated, such as medication administration, diagnosis, assessment and discharge planning (Rydon 2005). Brown (2000) found a dominance of the psychiatric model in community teams, affecting uniprofessional and multidisciplinary workings, in spite of some changes in the relationship between nursing and psychiatry (Brimblecombe 2005). When the caring relationship is ineffective, or is overtly or covertly discouraged by others, mental health nurses fall back on medical interventions as a default position (Bray 1999).

Binnie (2008) a former nurse who trained as a CBT therapist, described his experience of the transition and of the comparisons between the professions from a CBT perspective using a case study approach. His perspective of his experiences as a nurse, from the outside of the profession (therefore feeling no obligation to defend it), was that nursing was much more dominated by the medical model:

> "Whilst a CPN* I operated within the medical model. Although I tried to work creatively, I was influenced by the dominant profession, namely psychiatry; diagnosis and medication were the order of the day." (Binnie 2008:1275)

**CPN=Community Psychiatric Nurse*

It appears that the caring image, subscribed to but not necessarily adhered to by mental health nurses is also expected (and therefore reinforced) by client expectations. Rydon's (2005) study shows that clients also subscribe to the ideals of the mental health nursing profession, expecting treatment according to these attitudes of "being professional", "conveying hope", "connection", "working alongside", "being human", and "knowing and respecting the person". Expected skills included "counselling" and "touch", and practical skills of "education" and "physical assistance". A limitation of this study is that the sample (n=21) is drawn from mental health user groups. The author is not aware of any studies suggesting that user groups are representative of the general population, although a small study suggests that user groups have similar but stronger opinions than the general psychiatric user population, and thus not representative of the population (Crawford and Rutter 2004).

Chan and Rudman (2001) extend the notion of ideological conflicts, highlighting how the "Male" attitude of knowledge, technique, and professionalism contrasts with the traditional "Female" view of caring and servitude. Other contrasts are summarised in Table 2.1 below:

Table 2.1: Nursing Ideological conflicts (Chan and Rudman 2001)

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The values described above appear at face value to be dichotomous and inconsistent, however, such values are not necessarily always fixed and can be context specific. Kvarmstrom (2008) noted that expressed values are different when individuals perceive themselves as representing their professions, or where their view is challenged or threatened. In other fields it is known that individuals generally express views consistent with their desired self-concept (e.g. Markus and Wurf 1987). We noted earlier that the context of the question to some extent determines the answer – if asked an abstract question such as "what is a nurse?" a projection of self / role as "good" leads to an answer linked to caring. If asked a specific question "What does the nursing role actually consist of in practice?" the response consistent with "competent self" would be expected to consist of tasks linked to the medical paradigm (Furnham 2005).

In spite of an ideal of caring, the competing medical philosophy remains influential. Rolfe (2014:1179) describes the dominant nursing philosophical stance according to nursing practice as "technical rationality". He argues that this philosophy remains dominant in spite of the projected ideal of caring. Although the educational curriculum was altered to reflect humanism, incorporating the therapeutic relationship and a more individualised approach to care, ideologies in existing services were not changed (Porter 1993). Eventually some aspects of the humanist model (Rogers 1957) were adopted (e.g. supervision, reflection-on-action), especially in nursing education, but through a technical-rationalist lens, i.e. they are undertaken as technical tasks, not as individualised learning opportunities. Reflection-in-action would have challenged technical rationality, but this was not adopted by nursing (Rolfe 2002), therefore practice did not change.

Nursing is criticised for the difference between what is expected of the profession, and what is actually observed, and nurses have some awareness of this difference (Bray 1999) and express frustration at trying to balance this in all areas of their practice (Street and Walsh 1998, Cutcliffe and Barker 2002). As Dawson (1994) suggests that when nurse training changed to reflect a more

person-centred agenda, there were no parallel attempts to change the work culture to reflect this, therefore an aspirational and a practice role continue to function in parallel. Organisational policies also tend to have a strong bearing on both nursing practice and its delivery, which leads to fragmented and task-discrete work (Deacon and Fairhurst 2008), and this means delivery generally occurs through a positivist paradigm (e.g. if client is distressed, administer empathy). The medical model continues to exert a strong influence within nursing, especially within hospital settings (Cooksey and Brown 1998). One older study notes that in practice mental health nurses are even more medically focused than psychiatrists (Roskin, Carsen and Rabiner 1988) as well as social workers and psychologists; indicating a strong attraction to the medical model, which has the potential to conflict with CBT.

"Knowledge and technique" in carrying out a role appears to be important in mental health nurses compared with other professions which may have a more client centred, idiosyncratic view of the same problem, examples of these might be discharge planning or medication administering (Itzhaky, Gerber and Dekel 2004). As nurses are more used to working within hierarchies (Norman and Peck 1999) their professional identities may be weaker or less consistent than clinical psychologists, psychiatrists, social workers, and occupational therapists under some circumstances, and also more task discrete, because the practice of the managerial hierarchies take precedence over professional ones. The studies on nursing practice are relatively diverse, taken not only from nurses themselves, but also from observations on practice, surveys, clients, colleagues, and other professionals.

Early research into observation of nursing practice was psychodynamic in orientation, the main theme of which was that "the system" within which mental health nurses function on the wards (e.g. rules, professionality) acts as a defence against anxiety (e.g. Jacques 1953, Goffman 1968). The conflict of roles mean that the process of engaging with patients has a number of positive and negative reinforcers. Mental health nurses may feel valued when engaging with patients, but they perceive a risk in associating with "madness", and potentially becoming like the patient.

Furthermore, there is a risk that the nurse is rejected or their intervention fails, leading to feelings of inadequacy and eventually learned helplessness (Donati 1989). The defence of *professionalism* is developed as a coping strategy, with more extreme projections (Restraint, Electro-Convulsive therapy (ECT)) to contain client distress and maintain professional boundaries, and this is then taught and justified to more junior, enthusiastic staff (Bott 1976).

The actual experience of working on mental health wards is of high levels of unpredictability, emotion and risk (Hummelvoll and Severinsson 2001). There is evidence that nursing interventions such as avoiding personal contact with patients, use of medication, formalising interactions, etc., are more aligned to reducing emotion (the "noise level" of the presentation) than adhering to theory, even though there is a desire to interact with patients (Bray 1999, Baruch 1981). Some psychodynamic theorists argue that professionalization is a "defence" against the nurse's fears of experiencing emotions similar to the patient's (Menzies-Lyth 1988, 1990), or fear of identifying with insanity (Jacques 1953). Experienced nurses that remain in the profession for a long time continue to experience role discrepancy with these feelings, but become more comfortable with it over time (Takase, Maude and Manias 2006).

These studies, although contributing significantly to early understanding of nursing practice, all have a number of weaknesses. Firstly, they observe the process through the narrow theoretical lens of psychoanalysis, which has limited evidence for the model, and the limited lens drives a biased search for information confirming the model. Also, the model is limited to inpatient settings, and also in a historical time context of medicalised training for nurses and an "asylum" inpatient model.

Earlier in this section, mental health nurses described their profession with an interpersonal focus, consistent with the Nursing and Midwifery Council's view of the profession (Peck and Norman 1999). Other Professionals (occupational therapists, social workers, psychologists, psychiatrists, housing officers) were then encouraged to respond to this account. Occupational therapists and social workers both independently acknowledged that although there is an emphasis on professional

autonomy, the nurses fail to acknowledge technique. Psychologists are more specific, querying why they leave out medicalised skills such as monitoring of symptoms, health promotion, running clinics, giving injections, etc. The psychologists further suggested that nurses may be embarrassed about this role. Psychiatrists went further in suggesting that, although they do not feel valued, it is clear that they do not value themselves and what they actually do. “We believe you have unique skills... the trick of being ordinary, that you are undervaluing”. The descriptive analysis and comparatively small sample size limits the research, and it is not clear whether the results are generalizable beyond the team described, for which more research is needed.

Coatsworth-Puspoky, Forchuk and Ward-Griffin’s (2006) study of service users (ten from an inpatient setting, four from community) using an ethno-nursing method, categorises mental health nurses into “good” and “bad” examples of practice. “Good” nurses were friendly and validating, offered a glimmer of hope, there was some education and problem solving, and also an ending. “Bad” nurses were characterised by withholding support, then mutual avoidance and mistrust, leading to struggling on the part of the client. The ideals for what constitutes “good” practice confirms Rydon’s (2005) study, although the “good” nurses appear to be characterised by the effort they make (possibly in spite of the “system”) rather than the ideals or the outcome for the client.

A consistent theme in observational studies of nurse practice, and sometimes of interviews of mental health nurses asked to explain their practice, is a strong dissonance between what they want to do and what they are able to do. Bray’s (1999) ethnographic study incorporated both observation and interviews with nurses on three wards over a period of a year. The researchers also undertook “close observations”, effectively functioning as ancillary (unqualified) staff for the purposes of observation. The research also included patient interviews, and is one of only a small number of studies looking to explain or reconcile the apparent incongruence between what nurses’ say and what they do.

The study identified “difficulty working closely with patients”, “maintaining distance” and “congruent care” as principal themes. Mental health nurses did know their patients reasonably well, and were effective observers, but were perceived to have protected themselves from rejection by the patient. The most extreme example of this is “close observations”, where the patient needs to be *observed* at all times for the safety of themselves or of others. During close observations, an opportunity to engage with the patient is rarely taken up in spite of enforced proximal contact. In Bray’s study, mental health nurses also relied on distancing to protect from their own emotional distress. Nurses appear to try to actively engage with the client, but in practice know and observe the client while establishing some emotional protection by distancing interpersonally.

The literature on nursing practice does highlight a number of distinctive features. An example of this is observation skills, with nurses outperforming psychiatrists on observation of immediate needs, and outperforming psychiatrists and social workers in recall of immediate details (Barratt 1996). Although mental health nurses generally focus on more specific detail than other health professionals, and on broader observation, and have more awareness and responsiveness to the immediate situation, their formulation typically lacks structure and is “gut” driven (Hamilton et al. 2004).

Hamilton’s study on assessment (including preparation and recording findings) observed the discourse of a psychiatric nurse, a psychiatrist, and a social worker in assessing the same patient. The nurse had an empathic view of the problem, but this was expressed in medical language, and this was also found in Barrett’s (1996) study. All parties re-framed the discourse to some extent, suggesting that, although they see the same things, they have a professional cognitive map acting as a filter which leads to a different expression of the client’s problem (see Hall 2005).

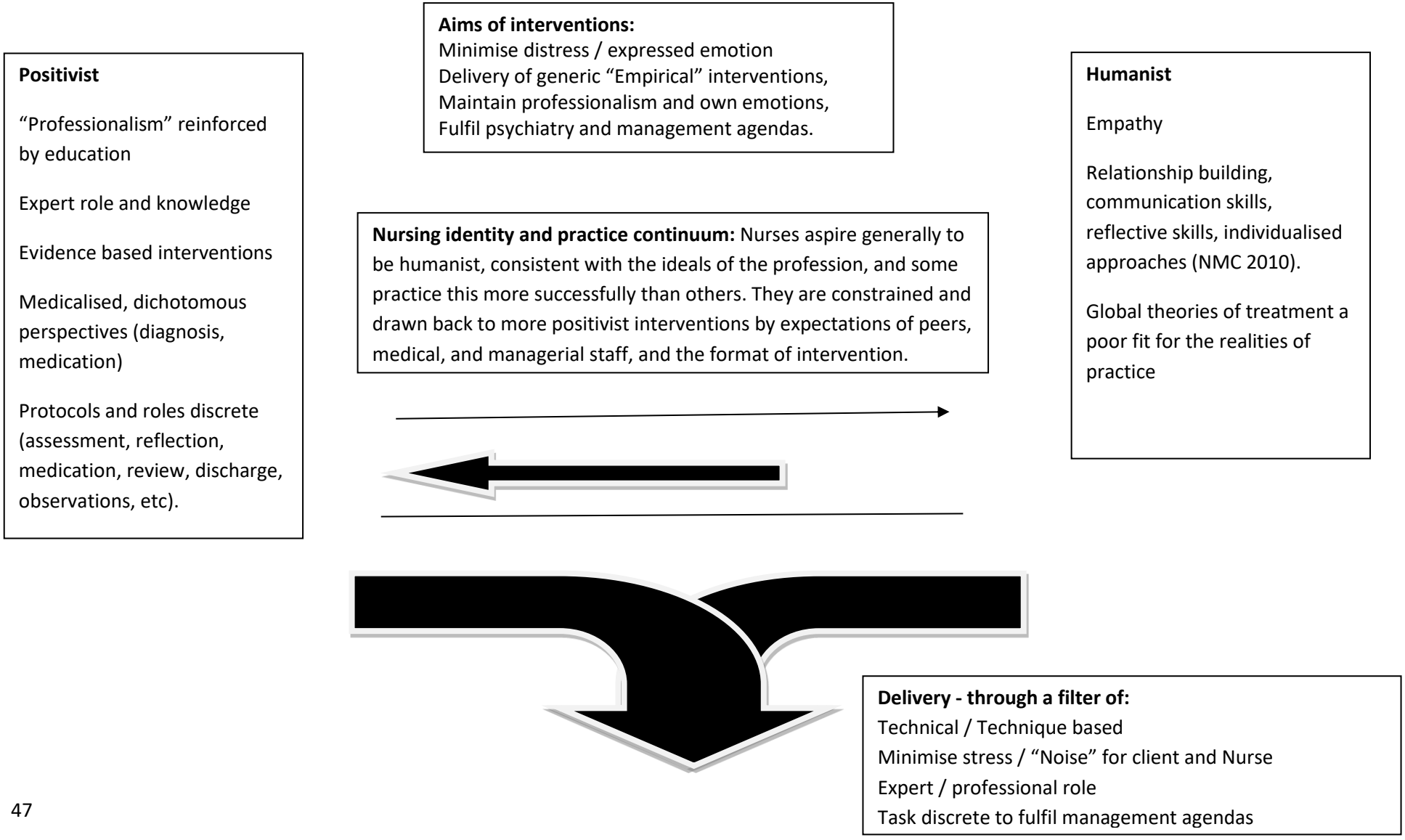
In summary, in spite of an attachment to caring values, there is also an attachment and practice of medicine (Itzhaky et al. 2004). In both inpatient and outpatient nursing, the setting of discrete tasks by managers has a tendency to fragment work and make professional influence weaker (Deacon and

Fairhurst 2008). To this end, a model is proposed: suggesting mental health nurses aspire to the principles of the profession, but are constrained by medicalisation (Handy 1985) (which includes influence by the pharmaceutical industry, Hemingway 2003, Lakeman 2010) and revert to the medical model when unsure. There may be some variation according to the conditions of the role, however the current task-discrete nature of delivery of care in the NHS tends to mean that nursing care is delivered in homogenous units (medication, 1-1, etc.) which focuses care through a task based framework, limiting the ability to deliver idealised care.

The task discrete aspect of the role is confirmed by Gijbels' (1995) research which summarises "Nurses valued and possessed a range of therapeutic qualities, but were unable to draw on these, leaving them mainly co-ordinating, administrative and managerial skills". The sense was of the nurse as a "jack of all trades", also employing roles of caretaker, mediator, role model, etc. when required. Statutory duties take priority over patient care, and there is limited control over when they are required to do certain roles. They note a continued tension between a co-ordinating role and a client centred role, and the lack of an ability to be assertive. Ellsom, Happell and Manias (2008) confirmed some of the findings in a larger and more coherent quantitative study (n=154 nurses) using questionnaires. He found that mental health nurses regularly were asked to go beyond professional and legal boundaries and that professionalism / therapeutic relationships not only are not valued, but also they are not protected. Nurses feel compromised in management roles when they have to implement policies not indicative of professional ideals (Croft, Currie and Lockett 2015b).

A model that synthesises the existing literature is described in Figure 2.4. Theory and practice is a complex mix of the psychiatric and the caring model, along a continuum. The caring model is aspired to, but there is a constant pull back to the psychiatric model due to skills, management structures, and expectations of others. Even if the caring model is adopted for short periods, it is delivered through a filter of institutional requirements, which considerably weaken the intervention.

Figure 2.4: A model synthesising literature of mental health nursing practice



It is important to consider whether inpatient and outpatient nursing represent two separate sub-cultures within nursing. Some studies drawing mental health nurses from both groups, such as that by Coatsworth-Puspoky et al. (2006) noted similar results for both groups with small samples. The culture of inpatient, acute, and chronic (*r*ehabilitation) nursing will be considered below, and community nursing will be considered later.

Although traditionally a "rite of passage" to working in other areas of nursing, Deacon, Warne and McAndrew's (2006) ethnographic research argues that the people that stay in inpatient nursing tend to be self-selecting in terms of a desire for strong teamwork and a tendency to thrive in coping with chaos and crisis. Emphasis on an ability to cope with uncertainty related to the most severe presentations, appears to be fundamental to inpatient nursing identity, as does using techniques to manage and cope with it. These techniques include medication, risk management, (Aarons and Savitzky 2006) observations (Barratt 1996), and also assessment, stabilisation of symptoms, and discharge planning (Fourie, McDonald, Connor et al. 2005). In inpatient settings, a number of papers have highlighted that mental health nurses have little protection from contact with patients, a strong ideology of team reinforcement, and high levels of distress, which both managers and psychiatrists require to be contained (Bray 1999).

To manage these issues and possibly protect against burnout, mental health nurses have developed a range of coping strategies, which have been observed from a number of perspectives. A range of emotional distancing strategies such as professional task orientation (especially compared with counsellors and psychologists) are known to be present (Roskin et al. 1988), and to a degree this is mutual between nurse and client (Tudor 1970, Lego 1999). Training of mental health nurses teaches concern, competence, and interest, but in the context of maintaining a "professional" distance (Dawson 1994). Peplau (1952) theorises that the professional closeness for mental health nurses does not concern closeness to patients, but a closeness to the truth of the patient's dilemma – which

requires a special type of detachment, and this is consistent with Bray's (1999), Roskin's (1988) and Deacon's (2006) work.

Whereas nursing roles on wards appear to be highly protected, this is less so in community nursing roles. In community settings, many mental health nursing positions are open to social workers and occupational therapists too, and notions of collaborative practice and inter-professional working have become commonplace in recent years (Department of Health 1990, 2000).

In spite of attempts at a managerial level to promote genericism in roles, this has had limited success in practice for a number of reasons. Studies in inter-professional education have repeatedly shown that it enables better understanding of others' roles and may improve collaboration, but it has no effect on professional identity or practice (Cooper, Carlyle, Gibbs et al. 2001, Priest Roberts, Dent, et al. 2008). A number of reasons have been identified by Peck and Norman (1999) for this including role -blurring, (e.g. approved mental health professional and Social work) which, although liberating for a small number (Brown Crawford and Darongkamas 2000) is linked with role strain and role confusion (Moller and Harber 1996) and is strongly linked with stress as well as causing inefficiencies (Wall 1998).

In spite of professional conflicts there are many examples of successful inter-professional working (see Leathard 2004). However this requires a strong sense of occupational role on the part of the professional in order that they are open about that role and willing to compromise (Payne 1982 (Ovretreit 1995). Brown et al. (2000) suggests that inter-professional practice may be increasing boundaries, possibly because role erosion generates uncertainty, leading to defensive practice, but also because awareness of others' roles reinforces a sense of their own occupational role. Generic models appear to be favoured by some patient groups (Williams 1999) and are probably favoured by policy makers as homogeneity facilitates implementation. Professional identification remains strong in community teams – for example members of most multi-disciplinary team professions including nursing see their profession's contribution as more valuable than others (Herman 2002) and this is

reinforced by the research of Hean, Clark, Adams, et al. (2006) who note that nurses tend towards superior beliefs about their practice compared to others in areas consistent with professional ideals.

McCallin (2001) states that outpatient nurses are perceived as more supportive than ward based nurses, although this could be due to the constraints placed upon the inpatient role. When visiting a patient's house, the balance of power moves towards the patient, not only because the nurse is unable to enforce the rules of the institution, but also because the patient is able to exhibit control by, for example, refusing to make the nurse a drink, or prompt them to sit down (McCallin 2001, Muir-Cochrane 2000). McCallin's study, using an interpretive ethnography methodology, notes that nurses make an effort to increase informality to compensate, such as hiding the name badge. The extent to which the treatment is compulsory and backed up by law affects the nature of the relationship, as does the type of visit (assessment, care and support vs administration of depot injections).

In terms of identification, community professionals are expected to identify with both the professional and team ideologies, which may not always be compatible (Barnes, Carpenter and Dickenson. 2000). There are real differences between professional groups in terms of culture and values (Freeman, Miller and Ross 2000), *s*tatus (Norman and Peck 1999) and *c*ognitive *s*tyles (Ovretveit, Mathias and Thompson 1997) amongst others. Stereotyping is not uncommon (Herman 2002) although shared aspects of training and ideology, common language, a positivist ideology, and shared problems can cut across professional boundaries (Temple and Bowers 1998).

Although there may be some differences between inpatient and outpatient nursing, there are suggestive features of a common grouping, both in terms of identification with an ideal, and practice. Identification with the nursing ideal remains consistent in spite of attempts to homogenise practice. Loxley (1997) argues that inter-professional relationships need to be developed through reliability and experience (i.e. not just imposed), and of equal status in order to be successful. The

ideals of the profession, the continued links to the medical model, and the task discrete nature of the specific roles work have all been identified as important characteristics of the profession

2.4.2: Counselling

Counsellors and psychotherapists are defined for the purposes of this study as accredited members of the British Association for Counselling and Psychotherapy (BACP), or equivalent. Professional bodies themselves tend to define counselling principles in a number of ways, including:

> "Counselling is a professional relationship that empowers diverse individuals, families and groups to accomplish mental health, wellness, education, and career goals" (American Counseling Association 2017)
>
> And a BACP definition is "a range of talking therapies... delivered by trained practitioners who work with people over a short or long term to help them bring about effective change or enhance their wellbeing" (Dale 2010)

Counselling is not completely homogenous in terms of training, identity or practice, because it is a relatively young profession (Lafleur 2007) and because the sheer variety of roles have a fragmenting effect on the profession (Capuzzi and Gross 1991). However, it is clear that there are a number of distinctive features, both in comparison to other professions and to CBT. In order to obtain BACP accreditation, training in one of three models (Humanistic, Psychodynamic or CBT, described earlier in this chapter) is required, although counselling practice may not reflect the training and according to one source there may be as many as 400 models, (Karasil 1986)

In spite of this diversity, principles appear to be consistent, and the above statements suggest there is an emphasis on client growth and potential, contrasting with the treatment of problems and conditions present in nursing practice. There is also a strong identification with the ideals of the profession which appears to be fairly consistent in spite of differences in training and areas of practice (Gazzola and Smith 2007)

There is some limited research in the area of counselling identity, especially in North America (e.g. Remley and Herlihy 2014), predominantly using survey based approaches, and occasionally interviews. The author is only aware of a single quantitative study: a web-based survey (Gazzola and Smith 2007), focusing on self-report of counselling identity in Canada *which* does not appear to have undergone any formal validity or reliability testing.

Counselling does not generally consider itself to be an "academic" profession in the way some modern healthcare professions have become over the last 30 years, emphasising expertise through training and knowledge. Henderson (2010) suggests that this has allowed counsellors to retain a "gut" response to what occurs in a counselling session, where this has been replaced by academic, rationalised responses in other professions, other than in crisis management. Therapists in the training stage are typically selected for empathy, intuition, and capacity for thinking (Mander 2004), and there is also a self-selection process in terms of personal vulnerability (Miller 1987, Merodoulaki 1994), learning styles (Torbit 1981) and early trauma and narcissistic needs (Barratt 2007), as well as female role attitudes (Mcgowen and Hart 1990) which pre-disposes the profession to confirmation of existing aspects of culture. The emphasis within training on practical skills and personal development further reinforces the person specification of a qualified counsellor (Beutler, Givner, Mowder, et al. 2004). Papers such as Atkins and Christensen (2001) review evidence that professional training or accreditation makes little difference to overall outcomes, arguing that this is possibly because part of the intuitive response is lost in professionalisation.

The right to practice the intuitive response appears to come from Rogers' (1961) assertion that evidence is collected from the senses and the relationship, and should be free of contamination from contextual factors, including regulation, authority, responsibility and the right to self-determination. This is deemed to apply just as much to therapists as to clients (Rogers 2009). The intuitive response is also important in responding to the needs of the whole person, not just the person in a therapeutic framework (Gale and Austin 2003). It may be that the essence of the

counsellor's professional skill is identifying individual needs and responding to the individual (in whatever way is necessary), plugging gaps that other models may miss. Counsellors recognise the pressures between conformity to expectations of the system within which they operate, and maintaining distinctiveness and fidelity to the principles of their clinical approach (McLaughlin and Boettcher 2009), in particular functioning within the medical model (Hansen 2003).

Many features of the counselling profession identified in the research literature do characterise it as a profession, but fail to differentiate it from other professions. Examples of this include understanding of the history, ethics, and pride in the profession (Remley and Herlihy 2014). The knowledge base overlaps with a number of professions, including more medicalised ones, and because there is less integration with other professions there appears to be a lack of awareness of the roles of others. The values that are present are not generally fixed and homogenous between counsellors, and are integrated with the "personal self" (roles, decisions, ethical values, perceptions etc.) to form a unique product with common features at the individual level (Gibson, Dollarhide and Moss 2010). One article appears to suggest that the skill of developing a personal narrative consistent with counselling principles is indicative of an advanced level of counselling ability to a greater extent than any particular practice skill (Winslade 2002).

One consistent principle that does have a degree of uniqueness is the emphasis on human growth and potential (Ivey and Van Hesteren 1990, Gibson, Dollarhide and Moss 2010) or wellness, (Mellin, Hunt and Nicholls 2011), and with that an emphasis on prevention, largely absent from more medical-influenced professions (Gladding and Newsome 2017). This paradigm shift requires an emphasis on the "client" rather than the clinician-based motives of "presenting problem", or "treatment", for the foundation of the professional engagement may be indicative of a strong female influence within the profession (McGowern and Hart 1990). The counsellor may also advocate for the client (Lafleur 2007, Gladding and Newsome 2017) and often this comes out of a broader philosophical social justice agenda typical in counselling (De la Paz 2011).

An important distinction from almost all other professions is the notion of "personal therapy" in training, requiring that counsellors adopt the role of client in order to address a number of personal issues. Although counsellors report the experience as beneficial (Macran and Shapiro 1998), there is no clear understanding why this is the case, although several hypotheses have been put forward. Firstly it enables the counsellor to address existing personal issues and become aware of "blind spots" when conducting therapy and separate roles of client and therapist (Grimmer and Tribe 2010). Secondly it enables the counsellor to experience the therapy from the client's perspective and thus empathise with them (Moodley, Shipton and Falken 2000). From a cultural perspective, aspects of training and knowledge are not "protected" by counsellors, but integrity of practice is (Folkes-Skinner 2010). Finally, it may enhance adherence to professional values, which is positively correlated with difficulty of initiation (Aronson and Mills 1959). While personal therapy is not generally used in mainstream CBT, there are exceptions to this in a small number of countries (e.g. South Africa, Laireiter and WilluzkI 2005)

The deliberate and conscious use of the self in the therapeutic context is certainly a significant characteristic of the profession (e.g. Reupert 2006). Andersen and Anderson (1989) further observe the extent of the role of self's use in the context of self-disclosure, although it is used within other contexts (e.g. role modelling). Awareness of the self in a therapeutic context is also a common feature (Veach, Bartels, and LeRoy 2001), and a range of stories and metaphors exist regarding the awareness of the counsellor's "shadow," – a range of alternative motives that the counsellor may have for engaging with a client in a certain way which require awareness if the counsellor is to be the agent of change (Wheeler 2007). This process of self-awareness can be time consuming and may not fit with managerial models of clinical practice (House 2012)

Although a number of distinctive features of counselling are present, specific clinical skills are mostly absent, because therapeutic processes appear to receive higher levels of emphasis than therapeutic skills (Gazzola and Smith 2007). The exception to this appears to be the management of empathy and the therapeutic relationship (Bor, Miller, Gill et al. 2008).There is evidence to suggest that the counsellor has considerable involvement in, and professional commitment to, the therapeutic process (Geldard 1999). Self-disclosure in terms of sharing emotional reactions is commonly used, but sharing of opinions or attitudes is rarer (Andersen and Anderson 1989). The emphasis on fostering human growth and development in clients (Robinson 1990) contrasts with the "treat and cure" medical model.

The absence of tangible technique and a perceived right to practice independently often brings counsellors into conflict with statutory systems in the UK (Mollon 2009), and many resent interference from those systems, for example:

> "For some counsellors, integration into healthcare systems is seen to be changing the nature of their profession for the worse" (Coleridge 2005:24).

The history of being external to statutory health service culture and politics (Foster and Murphy 2004) has had a number of effects that continue to shape the profession. There remains some evidence of protection of clinician and client autonomy (value neutrality, Suter 1998), and of the therapeutic relationship (e.g. full confidentiality), against an audit culture within the British National Health Service (House 2012). There is also historically less history of team working, and also note-keeping in an NHS context although this is changing (House 2011). Time-limitation of therapy and "professional" language is also a barrier to counsellor integration into statutory services (Coleridge 2005). The "paternal", dichotomous, NHS role contrasts with the counselling role and this can disempower counsellors when dealing with authority in the NHS (Foster and Murphy 2004). Counsellors perceive training for the adjustment to working in the NHS to be poor, with 70% perceiving their knowledge of severe mental illness to be poor (Fakhoury and Wright 2001). The

protection of autonomy also extends to a perceived inadequate time period to address client issues thoroughly and properly (Gibbons 2011). Pluralistic alternatives to the existing counselling healthcare framework have been proposed by Cooper and Macleod (2007) and House (2011), incorporating a loose framework of psychotherapeutic principles, and allowing for flexibility to respond to the client's needs using a range of practices within these principles.

Counselling's desire to sit outside established systems has implications for this research. CBT has come under criticism from counselling recently in two areas; that it has been complicit in state attempts to control psychotherapy, and that it has promoted homogeneity to the detriment of a diverse heritage in psychotherapy (Mollon 2010, Leader 2010). Counsellors view CBT as part of the established healthcare model (e.g. Mollon 2009) even though it is one of the main modes of practice for counsellors, along with psychodynamic, and especially humanistic approaches (Feltham and Horton 2012). However CBT is also part of a counsellor's identity, and counsellors remain conflicted about this (see March 1997) and the counselling models do not provide integrative solutions for this.

There appear to be some relatively strong characteristics in terms of a lack of reductionism, a protection of the right to a "gut response" at a deep level, the role of the counsellor in the relationship, and culture and rituals, many of which contrast strongly with the professional culture of mental health nursing, who rely on knowledge and technique in their practice. Empowerment, growth for therapist and client, the centrality of the client, and a need to have an autonomous response to the client's needs are all features. As a counsellor participating in Alves and Gazzola's (2011) research into counselling values puts it "I think [counselling] is just maintaining a healthy regard for the client; being very genuine with a client" (P.307).

In spite of counselling having a strong practice emphasis, there is very little research concerning the practice of counsellors. This may be because there is a limited emphasis on research within the profession, but also perhaps because homogenous themes are not expected, or even valued, by the counsellors. The lack of research in this area is acknowledged as a weakness. Although not the

purpose of part 2 of the study (to describe the counsellors' transition process to CBT therapist), how the counsellors respond initially to the training and differences in their practice between professions *will* be highlighted.

2.4.3: Knowledge, Skills and Attitudes (KSA)

Anyone can apply for an IAPT high intensity training position, even without formal training, provided that they can demonstrate the equivalent levels of knowledge, skills, and attitudes outlined in Table 2.2. This category of IAPT student incorporates a broad range of experience, usually including at least some psychotherapeutic practice (such as delivering psychotherapy groups) and at least a graduate degree in a relevant discipline such as psychology. Because competition is so high both for IAPT positions, the standard is high in this cohort, typically including masters' degrees and several years' experience. Some students most recently practiced as healthcare assistants, and others as Psychological Wellbeing Practitioners (PWP's) (with the latter becoming increasingly prevalent as a group in high intensity training). Although qualified and experienced, these students have not merged their experience and academic achievements into a professional qualification and role. The KSA criteria considered equivalent to a core profession is summarised in Table 2.2 below.

Table 2.2: the KSA Criteria

	CRITERION Knowledge - K	**QUALIFICATION**	**EVIDENCE**
1	Life Stages and Human Development	Knowledge of Life Stages and human development	Training Course or Reference
2	Health and Social Care Approaches	Knowledge of the delivery and legislation of health and social care through statutory and non-statutory bodies in the UK, e.g. Mental Health Act, National Service Framework	Training Course or Reference
3	Psychopathology/diagnostic skills	Demonstrate an accurate understanding of psychopathology and problem definitions	Training Course or Reference
4	Models of Therapy	Knowledge of a variety of theoretical models of intervention e.g. psychodynamic, biological, pharmacological, systemic and family, cognitive/behavioural.	Training Course or Reference
	Skills - S		
5	Competency in key relationship skills	E.g. Active listening, warmth, empathy, trust and rapport building.	Reference
6	Maintain and manage records and reports.	Maintain and manage records and reports.	Reference
7	Communication with services/colleagues.	Ability to maintain effective communication with referrers, colleagues etc.	Reference
8	Awareness of risk	Demonstrate a high level of awareness of potential risks to and from clients based on an ability to assess the probability of self-harm, suicide, hostility neglect, violence, exploitation, and of child protection issues, with a commensurate knowledge of their responsibility to respond to these.	Training Course and Reference
9	Comprehension of research	Demonstrate critical skills in reading, analysing and discussing published research studies	Training Course and Reference
10	Commitment to Ethical principals	Practice in an ethically appropriate manner with clients and colleagues e.g. confidentiality, non-exploitation.	Training Course and Reference
	ATTITUDE - A		
11	Suitable at a personal level	e.g. CRB checked	Reference
12	Enquiring mind	Approaches practice with curiosity and a spirit of enquiry.	Reference
13	Self-evaluation and reflection	Capacity to reflect on and evaluate own values, priorities etc.	Reference
14	Receptive to scientist practitioner approach	Receptive to scientist practitioner approach and empiricism.	Reference

The two largest groups of KSA students are graduate mental health workers (GMHW's) and PWP's. Both of these groups have struggled to establish a clear place within the NHS in the absence of a profession to support them. For example, Fletcher, Gavin, Harkness et al. (2008) note that vague guidance has led to inconsistency in role for GMHW's. Also, a poor public perception of the role (Gilbert and Russell 2006) and a struggle to establish an evidence base for the role (Currie, Finn, and Martin 2010) has also contributed to difficulties such as respect from other professionals, a consistent stream of referrals, etc. Fletcher et al. (2008) also note that the absence of a core profession not only creates an absence of clinical support, but it leads other professionals to view them as not professionally trained. Graduate mental health workers have had to compete with established professionals for pre-existing areas of work (O'Connor 2006). There is a lack of career structure (Schafer and Wycraft 2007), and it is generally viewed by many within the role as a transient role, with workers wishing to move on to other areas in healthcare such as clinical psychology (Harkness, Bower, Gask, et al. 2007).

Supervision within the role is generally present but not always appropriate to the clinical skills of the graduate mental health worker (Fletcher et al. 2008, Harrison, Lyons, Baguley et al. 2009), and at its best had a containing, rather than a therapeutic, effect (Lucock 2004). There do appear to be advantages in the lack of professionality as the absence of professional language and culture reduces the barrier between the Graduate Mental Health Worker and the patient (Schafer and Wycraft 2007) and positive feedback from clients appears to reflect the fact that the role is unaffected by professional ideologies ("Down to earth", "on the same wavelength", etc., Farrand, Duncan and Byng 2007). This appears to lend itself well to the evidence-based ideologies of CBT (Shone and Parker 2006). The only account of a transition from this role to an IAPT one (Chambers 2008) is largely a personal account of the process of the transition, rather than one in the context of previous roles and a description of learning processes.

Psychological wellbeing practitioners is a relatively new role within the English NHS, and it involves undertaking one year's training in low intensity CBT interventions, and have offered basic, manualised CBT approaches for mild-to-moderate cases of depression and anxiety. Training is limited for advanced interpersonal skills and models, and therapy is often delivered via telephone or by guided self-help, with fewer sessions, greater use of written material, and more emphasis on self-management (Bennett-Levy, Richards, Farrand et al. 2007). Evidence is robust for PWP delivery with this client group (Clark 2011). No qualitative studies concerning features of this group were elicited from the literature search, however as the role was only established in 2008, culture may still be being established. Supervision does vary from high intensity therapists as clinical and management supervision are integrated (Turpin and Wheeler 2011). Supervision has a greater emphasis on adherence to protocols rather than personal development and growth (Turpin and Wheeler 2011). Graduate Mental Health Workers and Psychological Wellbeing Practitioners were found to be similar in practice and skills (Farrand, Rayson and Lovis 2015), enhancing the argument for a homogenous KSA group.

2.4.4: Occupational therapy (OT)

Occupational therapists are defined in this study as registered as such by the Health and Care Professions Council (HCPC). Role descriptors suggest that they focus upon enabling individuals to assist with fulfilment of their occupations [i.e. roles] according to their change across the lifespan (Blair, Hume and Creek 2008). The greater emphasis on role transition within their work may have implications for their personal transition to the IAPT role, if they are able to put their theoretical knowledge and skills base into practice.

The review of occupational therapists is brief due to only being included in one part of the research, and because of a limited evidence base concerning the research culture. The theoretical basis for the

profession, the model of human occupation has been around since 1980 (Kielhofner 2007), but neither the practice of this theory nor the evidence base for the interventions it is based on have established themselves in clinical practice (Fortune and Fitzgerald 2009). This appears to be partly because the system within which they work does not value the ideal OT role *with* a focus on activities of daily living in rehabilitation (Peck and Norman 1999). The Occupational Therapy profession lacks a distinct knowledge base and there is also sometimes role ambiguity as they struggle to distinguish their distinct role as easily as professionals in multidisciplinary teams (Hughes 2001). There is also an emphasis on a process rather than specific techniques (e.g. "supporting", Thorner 1991), and an emphasis on patient advocacy, partly driven by a conflict between OT and medical values (Sachs 1993). The generic concepts of healthcare practice (support, relationship, multidisciplinary working, non-judgement, non-discrimination) is strongly identified with and there is no attempt to professionally claim this knowledge. It appears that the model is protected but the practice is not.

The practice of Occupational Therapy is partially determined by broader needs of the institution (Gooder 1997) and there is a lack of ability to implement their desired role (Lloyd, McKenna and King 2005) which is principally assessment and treatment of deficits in occupational performance (Thorner 1991). This sometimes leads to their "filling in gaps" in service provision in order to identify a role clearly (Fortune 2000, Morley, Atwal, and Spiliotopoulou 2011), often leading to an unclear understanding of their role from colleagues (Peck and Norman 1999), sometimes of a stereotyped nature (Atwal 2002).

In spite of this, Occupational therapists are more secure in their role than many other healthcare professionals, having the second strongest identification with the role after Clinical Psychologists (Norman and Peck 1999). They identify with inter-professional roles and have relatively permeable boundaries of their professional practice. They are the least abstract and most *pragmatic* learners

compared to other healthcare professions, such as nurses and social workers (Katz and Heimann 1991).

2.4.5: Summary of core professional culture and practice

Having identified that the best conceptualisation of the professional groupings being measured is that of a group from a social psychology perspective, a number of factors that define certain professions, in particular counselling and mental health nursing, have been identified. Many of these areas potentially conflict with each other and / or CBT, such as emotional avoidance in nursing, and the view that the therapeutic relationship is sufficient for change in counselling, and these conflicts have implications for the transition process. One major area of conflict is ideological differences between adherence to medical versus social-humanist models (Pilgrim and Rogers 2005), both of which have some influence in CBT. The relative paucity of literature on the culture of the KSA and Occupational Therapy groups may reflect a lack of tendency to identify with professional values and practice rituals. The lack of professionalisation of the KSA group may in itself be an important feature distinguishing it from other professions. Having established the literature on static factors related to transition, the more dynamic process of transition will be addressed next.

2.5: Transition of roles

An overview of the related literature suggests that the shift from a core professional practitioner to an IAPT High Intensity worker is a complex process which involves:

- a change in work practices
- an acquisition of formal and practice-based knowledge,
- a shedding of former knowledge that conflicts with the new knowledge
- a change in professional culture
- a change in professional group affiliation and identity
- managing the conflict of change and conflicting expectations of others

(Adams, Hayes and Hopson (1976), Ashforth (2000))

We have noted in 2.4 that the different core professions have a number of differences in identity and practice, which may impact on how they experience transition. In this section, the theory and evidence relating to the process of transition between roles and identities will be addressed, in the context of transition between the core professions and IAPT. This will include learning theories, especially in the context of building on existing knowledge, work based models, personal adaptation, and cultural adaptation. These theories all address the process of adaptation from different perspectives, and each of which have the potential to add a theoretical understanding to the research. This section reviews learning processes in transition, overviews transition theories, and reviews the theory and research on the process of transition through a sequential process from original group (i.e. core profession) to new group (i.e. CBT).

The research question in phase 2 of the research explores the experience of transition at the personal level. Transition is noted by Fenwick (2013) to be a natural process – people are always undergoing some form of transition. It is not a static or complete process and this "unstable equilibrium" should, in many respects, be considered the norm.

This suggests that the process of transition is dynamic and whilst a "core profession" may enter a stage of transition to an IAPT role, this transition is on-going which is represented through the 3 stages of the current research, prior to training, training and in practice.

Following a review of the major theories and evidence related to the above, an integrative model will be proposed.

2.5.1: The learning processes in transition

Reflective learning

CBT assumes that all learning comes from both cognitive and behavioural processes, driven by cognitive and behavioural theory (e.g. Hawton et al 1989). Specifically, problematic thoughts and behaviours can be replaced by more functional ones. The information processing model (e.g. Baddeley 1997) of learning may be adequate for some aspects of learning (such as learning information by rote). However, knowledge and classroom based teaching are not able to resolve knowledge conflicts, are insufficient for socialisation into CBT, and are unable to provide a sufficient grounding to enable competent evidence based CBT practice (Grant, Townend and Sloan 2008). CBT emphasises learning "from within" through guided reflection. The notion of learning in CBT therapist training has been influenced by this, and self-practice and self-reflection (SP-SR) for students typically forms part of the training process (Bennett Levy, Turner, Beaty, Smith, Paterson and Farmer 2001). SP-SR involves applying CBT skills to oneself, and using self-reflection on learning in a structured way, typically involving a co-therapist or a structured workbook (Chaddock, Thwaites,

Freeston, et al. 2014). Engagement in the process is necessary for a successful outcome presumably due to the centrality in the model of willingness to reflect, observe objectively, and desire to change (Bennett-Levy and Lee 2014). Students self-report gains using this model (Self-report of skill and observed quality of reflection (Chaddock et al. 2014), but the gains at a personal and professional level are idiosyncratic except for understanding of CBT (Bennett-Levy and Lee 2014), Bennett-Levy and Beedie 2007), and this could certainly be explained by the willingness to engage in the process of SP-SR, described above.

Figure 2.5: The Declarative, Procedural and Reflective model of learning CBT. Reproduced with permission from James Bennett-Levy

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The DPR Model of Therapist Skill Development (adapted from Bennett-Levy, 2006; Bennett-Levy & Thwaites, 2007; Bennett-Levy, Thwaites, Davis & Chaddock, 2009)

The principles of self-practice and self-reflection as a process of learning and of resolving transition dilemmas is based on Bennett-Levy's model of learning of CBT Bennett-Levy (2006); Bennett-Levy, Turner, Beaty, et al. (2001). This model emphasises three principal modes of learning, specifically declarative, procedural and reflective learning (see Figure 2.5) and specific teaching and learning methods have been identified as effective for each of these three domains; for example classroom teaching for declarative knowledge, role play for procedural skills, and diary keeping for reflective skills (Bennett-Levy et al. 2009, Bennett Levy 2002, 2003). Bennett-Levy acknowledges that the model is partly influenced by the student's willingness to engage with it, which may be due to core professional background, but also to other personal factors such as learning styles of the student (Rakovshik and McManus 2013). Reflection is viewed as the "engine room" of the model, and learning is unlikely to occur without a willingness to reflect (Chaddock et al. 2014). Although this model provides a very full explanation of the process of learning and reflection once present, within a CBT context and framework, it does not explain how students who do not want to reflect or adopt CBT identity and practice, start reflecting. Resistance to reflection may be present, which may mean the model is not adopted voluntarily by students. Similar models of learning new information that may conflict with current knowledge, such as transformational learning (Mezirow 1990) have the limitation of learning by relying on conscious processes, and learning can be resisted by the student if they are unwilling to engage.

Reflective and experiential learning and practice in healthcare is most significantly influenced by Schon's approach (1983) emphasising professional learning in the context of professional development as a way of growth beyond formal knowledge, through reflection on practice, and developing own hypotheses. The majority of the healthcare professions has adopted this model of advanced practice, including nursing, counselling, occupational therapy, and social work (e.g. Bulman and Schutz 2013), although the extent to which it is adopted in practice varies significantly. In particular, reflection-on-action, a deliberate form of reflection occurring after the event, is

relatively widely practiced whereas reflection-in-action, an intuitive response during the event, is not (e.g. Rolfe 1996). Both of these forms are central to CBT practice.

Although the value of reflection to both healthcare and CBT learning is not in doubt (e.g. Milne and James 2002) there are a number of limitations to this model. Perhaps the most obvious problem is that the theory needs to be taught in a didactic way initially and needs to be adopted internally by the professional. Professionals may adopt the skills but not adopt the practice, especially when existing pressures such as pre-existing frameworks for working (e.g. technical rationality) or simply because pressure of time impedes its full implementation (Rolfe 2014). Also, there are incidences of it being misused, reinforcing the status quo of existing practice rather than allowing for a critical viewpoint (Harris 1989). Although Schon's model does not preclude learning at an unconscious level, it does not explain it explicitly, therefore behavioural models with the potential to explain these processes require review, such as cognitive dissonance and exposure. Both reflective and dissonance based models are now reviewed for factors with the potential to contribute to an understanding of the learning process in transition.

Cognitive Dissonance

Cognitive dissonance theory (Festinger 1957) is able to offer a perspective on how conflicting attitudes and behaviours are resolved, and how reflection may start to occur, even if there is a reluctance to do so. This is significant within the context of the research as the conflict between existing attitude and new behaviour would be expected to happen during the training (Adams et al. 1976), such as the counsellor who has to confront the client, the nurse who has to engage at a more emotional level with the client, etc.

When there is a difference between a belief and behaviour, Festinger (1957) argues that the ensuing tension has drive-like properties and must be reduced. Research has repeatedly shown that the resolution typically leads to attitude change in favour of their behaviour, but the extent of that

resolution is determined by a number of additional factors (Reviewed in Cooper 2007). Some of these factors include the

- Induced compliance by reward (e.g. Festinger and Carlsmith 1962).
- Expectations of success in carrying out dissonant behaviour (Aronson and Carlsmith 1962), i.e if the likelihood of success is low, the behaviour will not be invested in, and the attitude maintained. According to this theory, if the therapist has a low confidence in their ability to undertake CBT skilfully in the future, the practice will not be invested in.
- The extent to which the behaviour can be easily retracted (Cooper, Zanna and Taves 1978), or the availability of alternative explanations. If the behaviour can be explained in other ways to self or others "I'm getting another badge..."
- The extent to which their discomfort can be expressed (Elliott and Devine 1999), if not expressed, there is not necessarily a drive towards resolution.
- The perception of free choice in making decisions (Linder, Cooper and Jones 1967). If behaviour change is perceived to be enforced, internal conflict with the attitude is not necessary as the dissonance can be projected externally.
- Inconsistent attitudes interfere with the individual's ability to process information and carry out tasks (Harmon-Jones 1999).

There have been a number of further revisions to the dissonance model in the last 25 years. Harmon-Jones (1999) argues and demonstrates that anticipation of aversive consequences is more significant in generating dissonance arousal than inconsistency, bringing it much closer to a behavioural exposure theory (Marks 1987). For example, Scher and Cooper (1989) demonstrated that dissonance and attitude change occurred when attitudes are consistent, but responsibility for aversive consequences were not.

In group contexts, dissonance of others can also be experienced if a group identity is shared, it is salient to the moment, and identity is high. If dissonance is experienced between personal and

group opinions, the dissonance resolves in favour of the group opinion under the above conditions, especially identification (Norto, Monin and Hogg 2003).

One limitation to the cognitive dissonance model is that attitudes are abstract and behaviours are specific (See 2.3.1). For this reason, they can be kept apart or function only in specific domains / contexts. An alcoholic can in principle have a general attitude of giving up in a therapy room, but in a public house, a specific behaviour may be more prevalent. However, exposure to a culture and staying with the dissonance may lead to resolution in favour of the behaviour in transition in spite of motivational intent (Taft 1977).

There are a number of potential implications for the current research. Cognitive dissonance is the only theory that suggests that the resolution is an effort to reduce the emotional conflict generated by dissonance as a result of the experience of the adaptation process only (without reflective awareness), although it is perhaps implicit in Schon's model of reflection. All other models discussed imply a resolution that is motivational in nature and / or that the change comes from a cognitive drive to do so. It is worthy of note that both Bennett-levy's (2009) and Schon's (1983) models incorporate an intuitive response to experience that sits somewhere in-between a deliberate response and a conditioned one.

Cognitive dissonance's strength is also its weakness, in that it only need occur when standard declarative, procedural, and reflective learning fail. It therefore is only useful in the limited context where there is overt dissonance and there is a resistance to conscious or intuitive reflection. Students on the IAPT training are required to submit reflective coursework, predominantly using Schon's model as a framework, including the source data for Part 2 of the current research. Schon's model predicts that a process of engagement in his reflective cycle predicts assimilation and adaptation in learning. The behaviour of reflecting in the coursework has the potential in those with an anti-reflective attitude to generate dissonance leading to an attitude change in favour of reflective practice, meaning that cognitive dissonance need no longer be relied upon. According to

cognitive dissonance theory, if there is a high emphasis on experiential behavioural learning and a strong pressure to conform applied by the new group, dissonance is more likely to be resolved (Cooper 2007). Having looked at the principal theories of how learning occurs, attention is now directed towards reviewing and synthesising information from the principal learning theories.

2.5.2: Overview of transition theories

The major transition theories are outlined in Table 2.4. No single theory on its own accounts for all the factors involved in the transition process from core professional to High Intensity CBT therapist. Social identity theories (Taifel and Turner 1986) focus on change in attitudes from the perspective of the individual, work-based theories account for processes involved in role change (Turner 1990, Ashforth 2000). Broader cultural models (Kim 2000) emphasise what constitutes full transition, whereas transitional psychology views the process from a wider lens of personal adaptation to change (Adams, Hayes and Hopson. 1976), whereas learning theories (reflection, cognitive dissonance, information processing) focus on how this process of change occurs, and also predicts how the method of learning influences the extent of internalised learning, which is known to be bound up in identity (Schon 1983, 1987).

It has been previously argued that social identity theory provides a useful framework for addressing social identity as a fixed structure, i.e. a relatively enduring identity such as a football fan. Although this can explain social identity of an individual once they have established themselves within a group (whether core professional or CBT), it does not explain the transition process. Social identity theories also struggle to acknowledge the continuum nature of the categorisation of individual / group behaviours, identity and self-esteem (Branscombe and Ellemers 1998). Adjusting self-concept to incorporate their new identity is an example of this (Amiot, Terry, Wirawan et al. 2010).

More modern perspectives of social identity have noted that competing social identities emphasise the drive like nature of resolving identity conflict (Currie, Finn and Martin 2010, Croft, Currie and Lockett 2015a), especially in the context of hybrid identity roles (such as a nurse-manager). They put forward the idea that individuals fall into a liminal space between roles, leading to identity conflict, driving identity transition (from Ybema, Beech and Ellis 2011).

Work-role theories of transition absorb some aspects of social identity into their models (e.g. Ashforth 2000), but place a stronger emphasis on cultural context, motivations for change, and outcome measurement. The ideas of personal development (the individual making personal adjustments to accommodate the role) and role development, adapting the role to one's own requirements, are contributed by Nicholson (1984), as an example of how individuals manage transitional change. Personal development and role development are not deemed to be mutually exclusive, and the process of adjustment (replication, absorption, determination, exploration) are hypothesised to determine the extent to which personal / role adaptation occur**.** There is some limited empirical support for this model (e.g. see Ashforth and Saks 1995, West, Nicholson and Rees 1987). Ashforth's (2000) work develops this model while also including elements of social identity theory. Ashforth's approach includes an emphasis on the processes and motivations for role entry and exit, incorporating aspects of social identity theories. Although perhaps the most thorough model, it is limited in that there is an emphasis on transitions in the context of moving between subordinate and management roles, and that is the basis for the majority of the evidence.

There are limited alternative models of transitions, although transitions between cultures have been widely researched (Kim 2000), and may be able to offer additional theoretical constructs. Brislin's (1981) model includes many similar features such as an impetus to start the transition process and conflict between roles. However, it does identify very clearly features of successful adaptation (See Table 2.4), and also does use terms from Seelye and Waselewski (1979) to offer explanations for non-adaptation (See Appendix 2). Brislin (1980) is also the only author to consider the consequences

of transition on the participants' once transition is complete. He found that participant's experience more broad-mindedness, a reduction in authoritarian values, increased internal control, and greater emphasis on achievement values. These factors appear to occur as a consequence of transition rather than a predictive factor of successful transition.

Kim (2000) takes the principles of cultural adaptation forward, although placing a greater emphasis on the role of emotion in driving the transition process, with high levels of crisis in transition associated with better outcomes (Eaton and Lasny1978). He asserts that interaction with a new culture can lead to adaptation regardless of the intent to adapt (Taft 1977) and notes that both explicit and subtle pressures to adapt may occur from the new culture. If correct, this theory would predict that students who are most willing to experience high levels of emotion involved with transitional conflict are more likely to show greater adaptation to the new group.

Transitional psychology, although less developed theoretically, addresses the issue of transition at a personal level more directly. Hopson's model (Adams, Hayes and Hopson 1976) maps the process of transition with a much greater emphasis on the experience of the individual, with a number of distinct stages (shock, provisional adjustment, inner contradictions, inner crisis, re-construction and recovery). The model broadly maps on to Kubler-Ross's (1969) stages of grieving model, adapting it from a loss-in-therapy to a transition-in-role model. Both models identify the early stages of loss or transition as an emotionally difficult process with similar distinct phases. A number of similar variants exist, such as Parker and Lewis (1981). Much more emphasis is placed on resolving emotional conflict than the other models, and also on the lived experience of the individual. Hopson (1981) argues that if the transitioner fails to overcome the emotional aspects, (specifically the grief

Table 2.3: A summary of models of transition from different perspectives

	Generic, factors for successful role change	Transition as Loss	Cultural adaptation and competence	Work-role transition
Focus	Turner 1990	Adams Hayes & Hopson 1976	Brislin 1981, Kim 2000	Nicholson 1984, Ashforth 2000
Stages	Impetus to change, conditioning factors in role negotiation	Well-being – First shock – provisional adjustment – inner contradictions – inner crisis – adaptation and recovers	N/A	N/A
Features / concepts	Re-allocation, resignation, non-adaptation	Partial recovery, extended crisis as alternatives to adaptation. Reaching crisis point takes time Personal differences in adjustment ability Resistance is an active process Transcends work roles. Complex learning and unlearning process Often high experienced emotion	Non-acceptance, Addition, substitution, synthesis, re-synthesis Short term lower expectations from new group facilitate change Instrumental (task) adaptation – risk of loneliness Social adaptation – frustration at lack of acceptance.	Initial "unfreezing"" Habit Change Revising objectives Disestablishing contacts/role exit Re-presentation of self Adaptation to new environment Role Vs Personal development Modes of adjustment: Ashforth includes social identity Psychological motives for change – Meaning, identity, belonging, control
Causes of non-adaptation	Structural autonomy of focal role (I.e. clear definition, free from management control) Unity, resources, and mobilisation of incumbents Mobilised client demand, support and trust Cultural credibility of new pattern of roles Institutional and legal support Encroachment of roles Lack of scarcity / monopolisability Support structures	Economic and emotional security Health Prior transition skills Supportive work environment Transitional support	Motivation to adapt Features of adaptation: Unconsciously relaxed with culture New group identifying them as "one of us" Unconsciously relaxed with group Identification Cultural competence Relationships and support Role acculturation	Role Requirements Motivational orientation Prior occupational Socialisation Organisational – induced socialisation processes Accepting environmental conditions Managing expectations Establishing role clarity

associated with the loss of the initial role, competency shame, and anxiety associated with role conflict and uncertainty), adaptation will not occur. This would suggest that successful transitioners will place an emphasis on attempting to manage and overcome emotional conflict in the process of transitioning to CBT. The assumption of high experienced emotion in response to change pre-supposes change is experienced as uncomfortable, which may not apply to everyone.

Table 2.3 demonstrates a reasonably high degree of convergence between these different approaches, although all the models emphasise different parts of the process. Aspects of convergence include a chronological set of stages, a resolution of conflict, the importance of support, and predictive factors for successful adaptation. There is a degree of variation in the definitions of outcomes (where defined, e.g. personal development (the individual fitting themselves into the role) in Nicholson's model could refer to either synthesis (merging roles) or substitution (swapping roles) in Brislin's Model), differences in the nature and definition of the group, and the order and process of change. Theories also differ on whether discomfort needs to be experienced to resolve conflict in the process of change.

2.5.3: Proposed model of transition

Although there are plenty of perspectives on transition (See Table 2.3), there is no single model that integrates the literature from all of the theoretical perspectives described above. An integrative model is proposed below. All models reviewed thus far describe a chronological process of transition, and this is used as the framework for the proposed model (Figure 2.6). The proposed model identifies a Preparation (Ending) (1), Transition (2), and adaptation (Beginning) (3) phase of change, following the structure described by Bridges (2009) model. The proposed model highlight*s* the critical issues and processes at each phase, and the relationship between each phase. It looks at criteria required to progress between these stages in addition to the stages themselves.

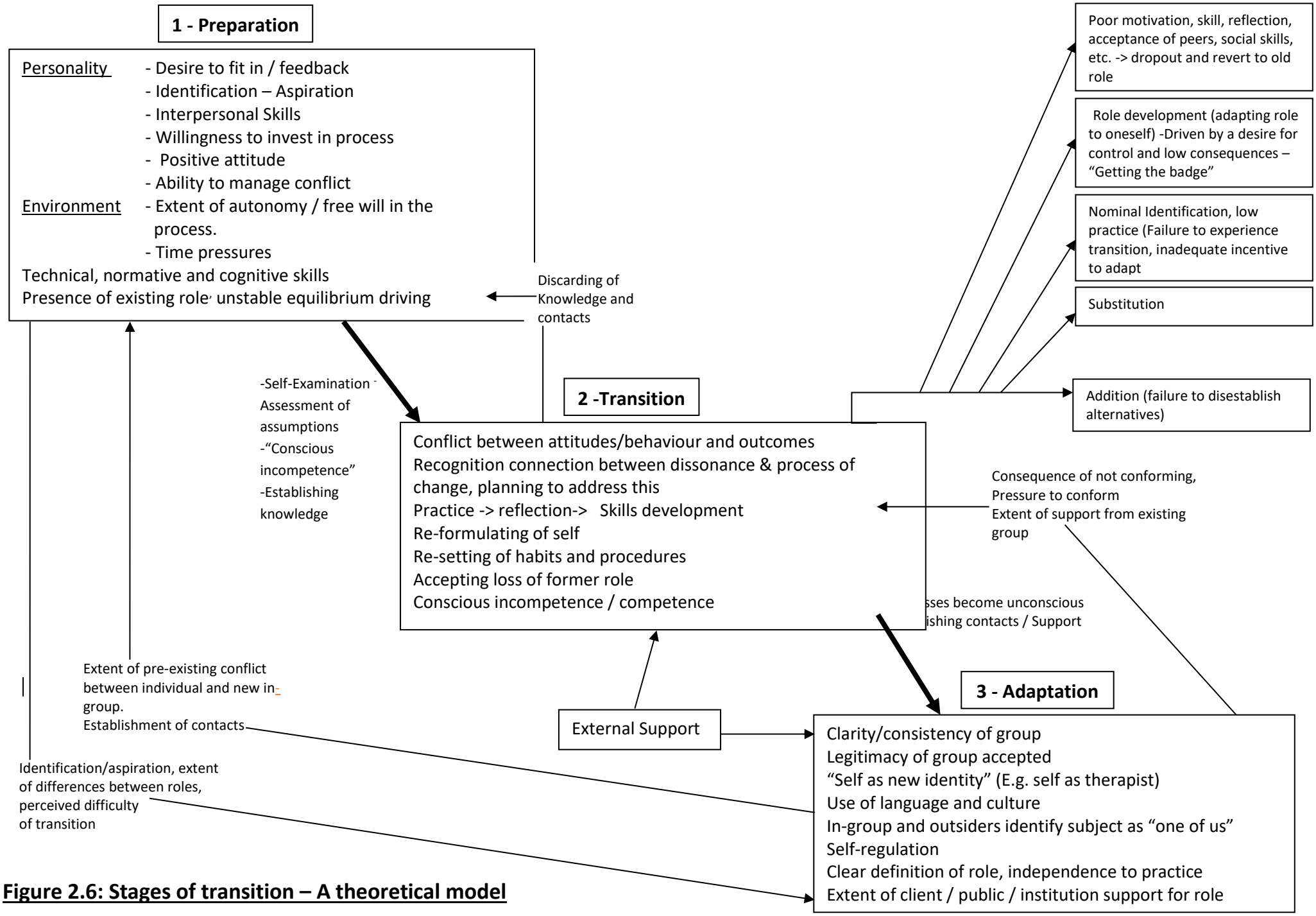


Figure 2.6: Stages of transition – A theoretical model

2.5.4: Stages of transition

Preparation Stage

A number of factors at this early stage of transition are known to determine the extent to which the transitioners engage with the transition process, and also affect outcomes, and these are briefly reviewed below. Nicholson (1984) and Adams et al. (1976) both have preparation stages to their models. There needs to be a psychological motivation to transition, given the investment required by the transitioner, and Ashforth's (2000) model proposes these are based on the psychological needs of identity, meaning, belonging, and control, building on Nicholson's desire to fit in (Nicholson 1984, Ashforth and Saks 1995), and a desire for feedback in the process. Identification with, and aspiration to belong to the new group is also important, and this can depend on the status of the old group, the new group, and the individual (Taijfel and Turner 1986, Branscombe et al. 1999). High performing members of low status groups are more likely to dis-identify with that group (Ellemers et al. 1990), and identity with a new group is stronger if it is considered to be more influential (Van Zomeran et al. 2010). People with robust self-esteem are more likely to change their attitudes under dissonant conditions (Steele, Spencer and Lynch 1993), probably because they are likely to have a greater range of social identities and be less dependent on, or attached to, a single social identity (Iyer et al. 2009).

Interpersonal skills (or social competence, Kim 2000) required in the process include an ability to manage (Interpersonal) conflict (Cooper 2007), skills developing and ending relationships, and identifying interpersonal practices and rituals that may not be formally taught (e.g. Bochner 2003, Scaife 2001). The latter may include an understanding of expectations of others, communication of social information, informal processes in appraisal, and "reading" the work structure and culture (Morrison 1995). There also needs to be an ability and a willingness to invest in the process of learning and reflection as well as the rituals of the new group (Klein 1977), sacrificing short term difficulties for perceived long term rewards, or as Kim (2000) describes it, a willingness to

deconstruct. These skills may have been those learned from previous transitions, and previous transition experience is useful (Adams, et al. 1976) including the intra- and inter-personal management of the transition process itself.

There is a wide range of environmental factors influencing readiness for transition. Examples of such factors include whether the change is enforced, whether the subject believes they are doing it according to their free will, and anticipated time pressures imposed on the change (see Cooper 2007, Ashforth 2000). The readiness of those undertaking the change is influenced by personal circumstances such as the economic and emotional security of the individual, and their general state of health (Adams et al. 1976, Williams 2008). The magnitude of the difference between the subject's existing group and the new group (and the extent of the learning, Hotho 1998), the perceived difficulty in making the transformation, and the permitted timeframe are also relevant as it affects the individual's confidence in coping with the change, and of a positive outcome (Ashforth 2000). Furthermore, perceived social support is important in transition preparation as it assists the transitioner psychologically through encouragement and understanding, and also practically, reducing the expectations and assisting with tasks both within and outside the transition (Moss 2008). Social Support includes peers, mentors, managers and family (Bauer and Green 1998).

Progression into transition is not a clearly defined state, but the process of self-examination and starting to test out new knowledge and habits may be relevant in initiating this process (See Mezirow 1990). This needs to be a proactive process if is to be successful (Major, Kozlowski, Chao, et al. 1995) and the emphasis has moved towards the individual as the agent of change as opposed to work, training, or professional organisations (Miller and Jablin 1991). This process includes the transitioner asking overt and covert questions of the representatives of the new role, and limit testing (Miller and Jablin 1991). Anticipatory identification may assist in motivating this process (described as a "transition bridge" in Ashforth 2000) – a process where transitioners attempt to internalise the perceived characteristics of the new role by role playing perceived characteristics,

internalising knowledge, “hanging out” with role prototypes, etc. (Ashforth 1998). The presence of scripts, (implicit or explicit), expectations or transitional rituals, also assist the progression into transition (Lord and Foti 1986). Conversely, avoiding identification, or coping through procrastination may delay the process (Adams et al. 1976).

Although engagement from the individual drives the progress into transition, the new role needs to also be proactive, both to promote the desirability of the transition and to give cues for new beliefs and practice (Ashforth 2016). According to Ashforth and Mael (1996) this is delivered typically through:

> *Symbolic management, including mission statements, strategies, stories, rituals, advertising, physical settings, and role models. (Ashforth 2000:154)*

Transition stage

Croft Currie and Lockett (2015b) incorporate the micro- and macro- aspects of the transition using the context of “liminal space”, falling between the gaps of different groups in the process of moving between them. Both the lack of rewards associated with not fully belonging to a group, , a lack of knowledge and understanding, and a conflict between roles (Hill 1992) is believed to drive a process in transition towards resolution of the transition (Beech 2011).

This does not occur universally, however. Croft, Currie and Lockett (2015b) has observed that in roles where liminality or a dual role is encouraged or even enforced, such as nurse managers, that occupants of these roles remain conflicted, therefore it can be assumed that significant accommodation may be required to reduce emotional discomfort, assuming that is desirable.

It has now been recognised that work based models have neglected emotion (Cascon-Perreira and Hallier 2012) but this is changing. Emotional crisis is central to transition based models, emphasising loss and adjustment as key processes driving this. Ashford and Taylor (1990) have observed that although arousal is universally present in transition, stress is not universally experienced, leading

them to conclude that the appraisal of the situation mediates the stress reaction, not the situation itself, and this is congruent with CBT learning as a therapeutic process (Beck 1976). In CBT, the uncertainty or absence of identity, meaning, control, or belonging, activates meaning in the individual linked to the ability to tolerate that uncertainty (Dugas, Gagnon, Ladouceur et al. 1998). This is described in the culture literature as ambiguity tolerance (Kim 2000). The cognitive and emotional conflict appear to lead to attempted resolution in at least two ways: firstly through an unconscious drive-like quality, and secondly driving a more deliberate process of testing, self-reflection and learning. Each of these processes are explored further in 2.3.4.

Research has tended to emphasise one of these processes to the exclusion of the other (Cooper 2007, Schon 1987). The more deliberate process in moving to CBT includes declarative knowledge and skills (knowing what), procedural knowledge and skills (knowing how) and reflection skills, a learning through reflection in-and on-practice, also a movement in emphasis in process towards a reflective learning style. It is important to try and understand which process is occurring in order to enable consolidation of learning.

In order to create a new role, a process of role exit needs to occur. This is a complex process which includes a discarding of contacts, discarding or down-valuing previous knowledge that is in conflict with the new role and, and creating an ex-role ("I used to do that, but I don't now", Ashforth 2000, Ashforth, Sluss and Saks 1995). The complexity exists because the relative influence of each role determines the extent of the role exit. If the transition is voluntary and wanted, there would be an expected aspiration towards the new role, and this would facilitate role exit. By contrast, an enforced and unwanted transition may lead the transitioner to continue to identify with the original role, often adopting a sentimental view of it (Mael 1988, Mael and Ashforth 1992).

The complexity of role exit is further compounded by the perceived and actual consequences of doing so. The process of "losing" identity and skills (Including historical coping skills), is emotionally

exposing, but with CBT it is required before new skills can be learned. However, new skills can take time to acquire, which risks creating a liminal space between roles. Such role conflict is known to inhibit learning (Brett 1980). During that time, the transitioner may have to accept a novice role in lieu of an expert one (Adams et al. 1976, Hopson and Adams 1976, Ashforth 2000). This loss has a considerable influence on Hopson's model as this generates a grief reaction leading to an emotional crisis.

Even if role exit successfully occurs, there is no guarantee that the IAPT student will have the skills or the motivation to fully enter the new role. The new group, in this case CBT, would be expected to play a significant role in the transition process, in the extent that it supports people aspiring to enter the group, while preserving the group's boundaries (Williams 2008). The extent of the influence of the new role, both in absolute terms and relative to the former role, is further determined by the extent to which aspirants and the general public accept its legitimacy, that there is a demand for the groups services from the public, and that there is an independence of practice of the group (e.g. from management) (Turner 1990). The new group's clarity and consistency is also important (Turner 1990). Learning structures and processes, and aspects of socialisation and support have already been identified as influential, but the extent of pressure to conform and the consequences of not conforming require further exploration. The extent to which CBT takes a pluralist or an assimilative attitude towards the students will also be influential (Ashforth 2000). This needs to be held in balance as exerting conformity pressure may increase compliance (Kim 2000), but risks reducing compliance as a result of enabling the student to externalise the dissonance.

In the first part of this research, the independent variable, the Cognitive Therapy Scale (Revised) (CTS-r, described further in Chapter 3), applied 6 times in the year, requires the student to behave according to the principles of the new role of CBT, and imposes sanctions for not doing so (i.e. failing the course). According to cognitive dissonance theory, this would be expected to lead to attitude resolution in favour of the practice of CBT. However it does risk inducing further dissonance via

competency shame (Gilbert 2007, Grant 2011), especially as the loss of transferrable therapeutic interpersonal skills in the early stages is known to occur (Henry, Schacht, Strupp, et al. 1993).

If no pressure to change is applied, or new behaviours can be explained in ways other than new group identification, or learning does not occur for any other reason, then a failure to adjust (Kim 2000), role development (Nicholson 1982), or extended crisis (Williams 2008) may occur. The recognition that dissonance is part of the transformation process is important, managing difficulties in learning, accepting loss (possibly including status and expertise) of former role. A process of re-formulation of self, and some re-setting of habits and procedures (language, norms etc.) is important (see Bowditch and Buozeno 2005). If this does not happen, a range of alternative outcomes can occur, including substitution. A discarding of some previous knowledge and contacts need to occur, as social contacts from previous roles can serve as strong reinforcers of that role. If this does not occur, the change may not be internalised and more than one identity may exist in parallel according to the situation described as "addition" by Brislin (1981). If the therapist "survives" the process rather than adapts, the transition is delayed (Sims and Veres 1987, cited in Robinson et al 2012)

Adaptation

If the new groups provide the resources required for the transition process to occur, the new group meets the individuals psychological needs (e.g. autonomy, social needs, stability), and when past identities are positively comparable with the new role, adaptation is easier (Adams et al. 1976), however this is not easy to achieve, and adaptation is not guaranteed. Transition is complete when the incumbent integrates the group culture into their personality, and also self-regulates their behaviour in accordance with group norms, feels unconsciously at home with the culture, identifies with it (Brislin 1981), and uses the host reasoning and logic (Gumpertz and Cook-Gumpertz 1982). There is a cultural competence in the new roles and established Individuals within the group are able

to recognise the incumbent transitioner as “one of us”” (Brislin 1981). The incumbent also needs to have a schematic representation of themselves as performing the role within the group (e.g. “self-as-therapist”, Bennett-Levy and Beedie 2007). Any synthesis needs to be an internalised process for adaptation to occur, not simply compliance (Kulman 1958). There is a subsiding of stress (Kim 2000).

2.5.5: Conclusions

Transition is a complex process that is slowly starting to be better understood. It can be viewed from the perspective of the transitioners or organisations, both of whom may have different goals. The state of transition can be viewed as a liminal space between roles, which can generate high experienced emotion for some. Even if desired by the transitioner, it is a process involving complex learning and social etiquette, personality factors, and environmental conditions that can lead to a range of outcomes; one of which is full transition.

2.6: Chapter summary

The literature necessary to address the research question overlaps a range of fields, including social psychology, sociology of professions, transitional psychology, learning theory, and culture within core professions and CBT. It has been noted within this chapter that professionalism, although not applicable in the traditional sense to the groups studied, is likely to be influential due to on-going adherence to rituals and transcendent values. Examples of this are found in the literature on both nursing and counselling culture.

The processes and outcomes of role transition reveal it to be a complex process that is not guaranteed to be successful or complete. From a number of different perspectives (transitional psychology, cultural adaptation, work cultures, learning theory), there is an overlap in understanding of factors influencing the transition process in the context of both the transitioner and the environment and also factors defining a successful outcome. Both behavioural and reflective learning may be influential in the process, although the principal model of learning CBT (SP-SR) primarily emphasises the reflective process. This research has the potential to add to the existing theory of learning CBT by considering how core professions approach this learning process.

Chapter 3: Initial assessment of skills in CBT across the core professions

Chapter 3: Initial assessment of skills in CBT across the core professions

This chapter presents three quantitative studies and represents Phase 1 of the research, working to an overall aim of "Assessment of core professional CBT skills on entering IAPT training". This section of the research is sub-divided into 3 parts; part 1a, which has an objective of "To assess whether there are differences between the core professions in 12 generic and CBT skills pertinent to CBT practice on entering CBT training"; part 1b has the objective "To assess for differences in the students belief about their level of generic and CBT skills, between the core professions";
Part 1c has the objective "To assess whether supervisor and student assessments of the 12 generic and CBT skills are different in each core professional grouping". The literature in Chapter 2 confirms differences exist in both identity and practice between the core professions involved in this research, and indicates the need to investigate these core professions initial skills and level of reflective ability in CBT.

3.1: Method

3.1.1: Choice of design

The choice of design was applied on the basis of the participant characteristics, available research tools, and ethical principles. In the early stages of training, participants may not have adequate knowledge or understanding to report on their skills subjectively, and supervisors may not have sufficiently specific knowledge about their supervisees to do the same, rendering a qualitative approach less appropriate.

The presence of an available measure to rate multiple domains of therapist skills also significantly influences the use of a quantitative design in part 1a. The measure concerned, the Cognitive Therapy Scale (Revised) (CTS-r) (Appendix 3), which is well validated as a supervisor-rated objective measure,

reliably distinguishing between different levels of therapist skill in 12 domains (see 3.1.3 and Blackburn, James, Milne et al. 2001). The Postgraduate Diploma in High Intensity Psychological Interventions course requires six supervisor and supervisee CTS-r rated therapy sessions as part of the course requirements, one of which must take place within the first ten weeks. Therefore, the data to undertake this study is collected even in the absence of the research, meaning that the participants have minimal interference.

3.1.2: Research design

The research design is a quantitative, quasi experimental, between groups (4) design. Consideration was given to an additional within-subjects design, comparing professional groupings across the training, and additionally at the end of therapy. This was rejected because all students are required to pass and score an average of x- =3 on the CTS-r by the end of the course. The vast majority of the CTS-r domains would be expected to be in the range of 3 (competent with some problems) to 4 (good features with minor problems). The higher scores 5-6 is considered “expert” range and not typical in students, and therefore a typical range of 3-4 is too narrow a window to discriminate between groups post training. In the context of the above, any significant improvement over the training is more likely to be determined principally by their initial starting level of skill and development, which is already being assessed.

All of the submitted therapy sessions were marked by supervisors, and by the students themselves. Comparing the students’ and supervisors marks provides an opportunity to assess the students’ reflective abilities, i.e. how accurately they can perceive their own skills. This will be researched in Part 1b and will also be a quantitative, quasi experimental, between groups design.

3.1.3: Materials

The Cognitive Therapy Scale (Revised), or CTS-r, developed by Blackburn et al. (2001) is certainly the most frequently used measure of cognitive therapy in the research (see Clark 2011). It is a 12 item measure which is used as a form of assessment of therapeutic skill in cognitive or cognitive behavioural therapy. (A description of the 12 items is contained in Appendix 3). The tool is principally used by supervisors as a way of measuring competence (James, Blackburn and Reichelt 2000) but it can also be used as a reflective tool by the therapists themselves, (Brosan, Reynolds and Moore 2007). It should be noted that assessment of competence relates to the 12 domains only, and there is no evidence suggesting that CTS-r competency translates to client outcomes at an individual or domain-specific level (Branson, Shafran and Myles 2015). The measure itself consists of a 0-6 scale, measured in half point intervals, with zero reflecting a lack of competence, and six, a high level of competence, based on Dreyfus's (1989) system of evaluation of (experiential) skills acquisition. The concept underlying each domain is also defined, see Appendix 3.

The main alternative measure that remains in use is its forerunner, the Cognitive Therapy Scale (CTS) (Young and Beck 1980, Vallis, Shaw and Dobson 1986)). A number of alternative measures were also reviewed, including the Helper Behaviour Rating Scale (Shapiro, Barkham and Irving 1984). However, none of these measures had sufficient construct validity – they were not measuring cognitive therapy sufficiently in either general or specific terms and / or aspects of cognitive therapy competence were not present**.** The CTS-r appears to overcome the criticism levelled at the CTS, for example by Shaw, Elkin, Yamaguchi et al. (1999) that the original version omits critical aspects of CBT competence, and by Blackburn et al (2001) that there is poor face validity, and that there is considerable overlapping of concepts in the different scoring domains (Milne, Claydon, Blackburn, et al. 2001). Since this research in 2001, the CTS has become much less used, and there has not been any attempts yet to overcome the issue of face validity. There are also measures that are over specific in their application such as the Cognitive Therapy Competence Scale for Social Phobia (Von Consbruch, Clark and Stangier 2012), which measure a subset of cognitive therapy and does not measure application of skills across a broad enough range of presenting problems, and therefore not

suitable for this study. A new measure, the Assessment of Core CBT Skills is currently being piloted to assess clinical skills through supervision, (Muse, McManus, Rakovshik et al. 2017) but this measure does not measure clinical skills directly through therapy sessions.

Blackburn et AL's (2001) study included data on the internal consistency of the CTS-r. Cronbach's alpha for each of the four raters on the 13 item scale (one item was later dropped due to conceptual problems) were 0.92, 0.95, 0.97, and 0.95, demonstrating robust internal consistency (Blackburn et al. 2001). Average inter-rater reliability (using Pearson coefficients) between the four raters was 0.66 ($p<0.01$) although one rater was less reliable than the other three, and when this was taken into account, Pearson r was 0.77 ($p<0.001$). Inter-rater reliability for the individual domains were all significant at the $p<0.01$ level; this compares favourably with its predecessor, the CTS, which had some non-significant items (Dobson et al. 1985). As noted above, it was later discovered that training improves consistency of rating (Reichelt et al. 2003). It is worth noting that the raters in the original CTS-r research were described as "very experienced" by the authors. The supervisors / raters in this phase of the study, although all experienced therapists who have regularly self-rated using the CTS-r, have differing experiences of regularly rating others. To this end, regular shared ratings of therapist tapes were undertaken in this research with the supervisors in order to help some supervisors gain experience, and to discuss and correct any major differences. This has occurred on 15 occasions since September 2009, and example data from these supervision meetings is represented in Appendix 4, in order to provide data that supports consistency in supervisor ratings in this research.

There are a number of further advantages to using the CTS-r over other measures in addition to internal consistency. It is the only measure of cognitive therapy competence that is widely appearing in the literature at present, including in randomised control trials (Edwards, Parish, Rozen, et al. 2016), so it is useful as a comparison with other studies. It has been validated on students as well as competent therapists (Blackburn et al. 2001). Training in the use of the measure also improves

reliability (Reichelt, James and Blackburn 2003) and which occurred with the supervisors taking part in this study. It is also the measure of competence suggested by the CBT accrediting organisation in the UK, the BABCP (BABCP 2016), and is also the only suggested measure of competence by the national IAPT guidance (Clark 2011), and as such, is the measure of competence used on the IAPT training courses.

If a measure has good discriminant validity, there would be an ability for it to distinguish between different levels of the concept that it is trying to measure, in this case therapist competence. Blackburn et al. (2001) assumed that as students progressed through training competence would increase, and this was borne out by assessing 11 trainees working with 2 different cases at different stages of training, taking the average CTS-r score with each case, and using a paired t-test for comparison. The results of Blackburn's test confirmed that students improved significantly ($p<0.02$) suggesting discriminant validity overall. Not all domains were significant, however, it is quite possible that therapists in some domains already have skills in some areas as a result of exposure to them in non-CBT training, which would be consistent with some of the ratings in this study (e.g. collaboration, interpersonal effectiveness).

3.1.4: Participants

The participants were all students on the Postgraduate Diploma in High Intensity Psychological interventions at Coventry University over seven intakes: 2009-10, 2010-11, 2011-12, 2013, 2014, 2015, and 2016. A total of 126 students completed one term and one CTS-r on the course, and were invited to participate in part 1a and 1b of the research. Students were reminded that participation was voluntary and that they could withdraw their consent at any time both verbally by the researcher and in the Participant Information Sheet. Eighty one participants consented, or 64 % of those invited to do so. Social workers (2 consenting) and Clinical Psychologists (2 consenting) had to

be excluded as there were not significant numbers of consenting participants to make the group sizes viable for research purposes. One participant was excluded as she was practicing both mental health nursing and counselling immediately prior to the commencement of the course and was excluded on the grounds that the core profession of most significant influence was not clear. It is acknowledged that the research may not apply to those with multiple core professions

Table 3.1: Participant groupings

Participant grouping	Participant numbers
Mental Health Nursing	27
Counselling and Psychotherapy	16
Knowledge, Skills and Attitudes	27
Occupational Therapy	6
Total	76

Each of the core professions forming the independent variables are outlined below.

Mental health nurses

Mental health nursing as a grouping is characterised by people practicing based on registration to parts 2 and 14 of the register of the Nursing and Midwifery Council – having completed a course of training in mental health nursing. A total of 27 mental health nurses were recruited.

The extent of homogeneity of mental health nurses as a group is covered in chapter 2, with some consistent and unique features apparent. There has, however, been some commentaries about

potential diversity in culture and practice between inpatient and community nurses, (such as a change in the client power base in the community, McCallin 2001). This is acknowledged as a limitation, however the researcher took the decision not to ask about the last workplaces of the participants. The blurring of boundaries between inpatient and outpatient roles, such as crisis teams, means that mental health nurses exact roles would need to be obtained, and even then measuring the similarity to traditional inpatient or outpatient roles would be complex and ambiguous. Collecting this additional data could also compromise anonymity as the researcher works in the same area. Also, the threshold for admission to community services has increased significantly, and the complexity of clients has become more of a unifying feature between ward and community in recent years overcoming the main historical area of divergence.

Counsellors

Counsellors as a group are registered either with the British Association for Counselling and Psychotherapy (BACP) or the United Kingdom Council for Psychotherapy (UKCP). They identify themselves primarily as counsellors and/or psychotherapists. Although they do not necessarily have adherence to a single model of practice, there are a number of principles and practices, outlined in chapter 2, that characterise them as a group, distinguishing them from both other groupings and cognitive behavioural therapists. Examples of these are autonomy of practice, and a high emphasis on process. Some therapists may integrate CBT into their practice, and describe themselves as integrative counsellors, but it is not usually their primary therapeutic orientation. Thirteen are employed as primary care counsellors within the NHS, sometimes including additional private work, with the remaining three in private practice. Sixteen participants were recruited to this group.

Knowledge, Skills and Attitudes (KSA)

If students do not meet a series of core competencies as a result of their core professional training, they are required to demonstrate that they meet these competencies by demonstrating knowledge, skills and attitudes in other ways. Typically, this group has both a high level of academic achievement and a high level of experience in healthcare and basic psychological skills, but these have often remained separate, rather than merging together into a core profession. Master's degrees in psychology and healthcare subjects and considerable CBT experience (without professional training) is not uncommon. Many of the students comprising this group included Graduate Mental Health Workers, and Psychological Wellbeing Practitioners. A number of practitioners also have forensic CBT experience. Twenty seven participants were recruited to this group.

There are some limitations to categorising this group at all, or as a united concept. In some respects it is a group formed from exclusion from other groups, but the lack of restraint due to professional ideals, and the direct experience of CBT practice without contamination from other models or approaches could be considered defining characteristics. The extent of the homogeneity of this group with regard to CBT skills and reflective abilities CBT can be observed from the outcome data from this phase of the research.

Occupational Therapy

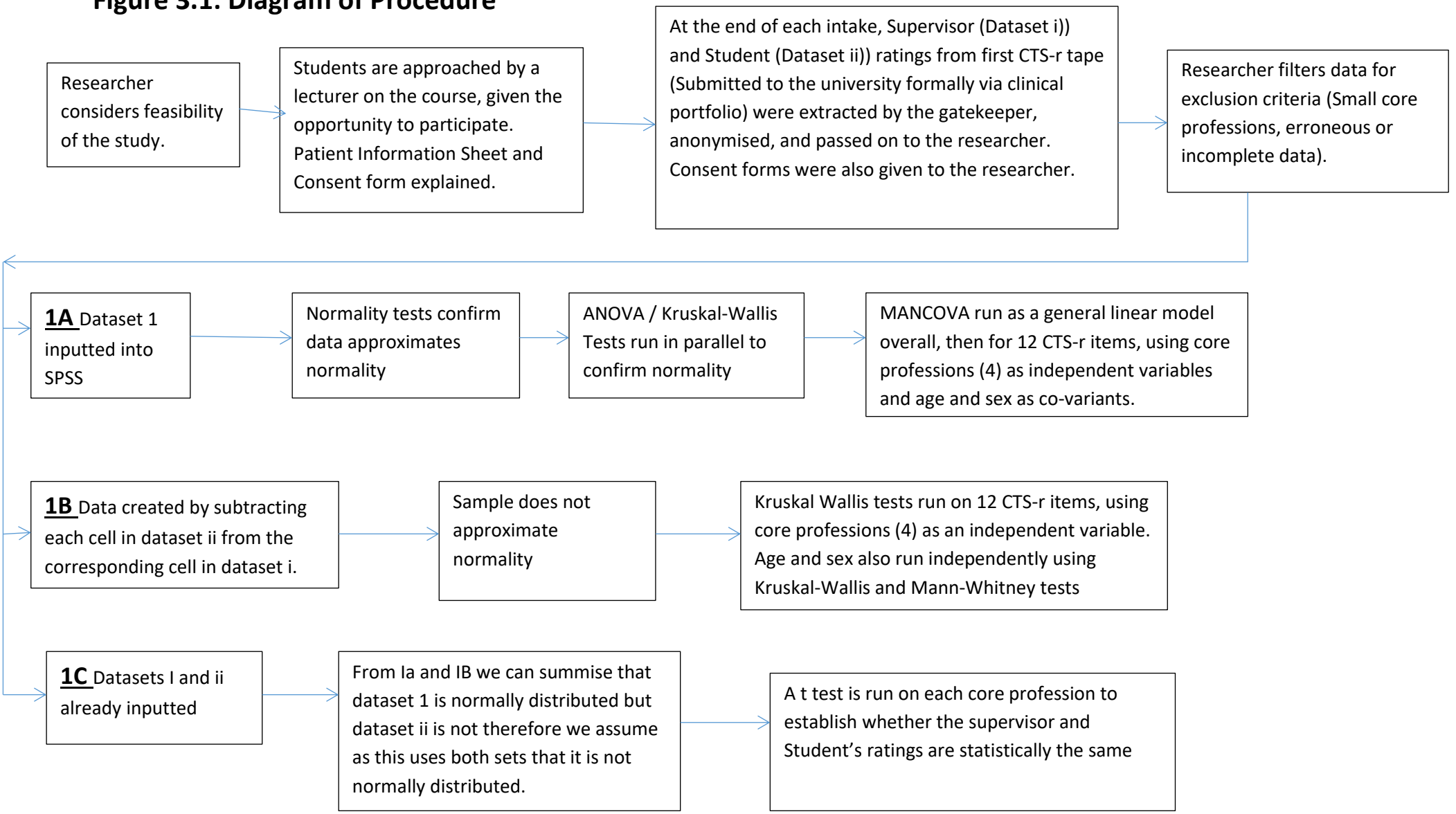
The Occupational Therapy group are defined as being registered as an Occupational Therapist by the Health Care Professions Council (HCPC).The training required is considerably broader than just mental health, incorporating considerable aspects of physical health rehabilitation. Occupational Therapists are often a small proportion of established teams (compared with mental health nurses), and tend not to have strong professional networks in organisations (compared with counsellors),

therefore a stronger multidisciplinary influence may be expected, and this has been reported in some studies, **(**Hughes 2001).

3.2: Procedure

A summary of the procedure is described in Figure 3.1. Consideration as to the feasibility of the study was considered, and the appropriate design was decided upon, and hypotheses were generated. Ethical approval was obtained from the appropriate UK university, and the NHS regional ethics committee were contacted, but stated that ethical approval was not needed due to no direct contact with patients being undertaken (Appendix 7). After ethical approval had been granted, a gatekeeper (the course director) was recruited to anonymise the data. The students were then approached by a lecturer on the IAPT course over several intakes, and offered the opportunity to participate, and explained the context of their participation through the Participant Information Sheet, and had the process of consent explained to them (Appendix 5). Consent forms (Appendix 5) were collected by the lecturer and given to the gatekeeper. The gatekeeper collected the CTS-r data from those consenting through their supervisors, anonymised the data, then added the required demographic data (sex, age category, professional grouping). Once all the data was received by the researcher, the gatekeeper gave the researcher the consent forms). The researcher then filtered the submitted CTS-r's for exclusion factors (core professions with insufficient data, multiple core professions, erroneous or incomplete data on the CTS-r's, etc.).

Figure 3.1: Diagram of Procedure



3.3 Ethical considerations

The overall aim of research is to further knowledge and understanding (Koocher and Keith-Spiegel 1998). However, research involving other human beings has frequently in the past, whether deliberate or not, infringed basic ethical principles and/or human rights (E.g. Coolican 2009). As a result, all formal research in the UK requires adherence to, or at the very least, consideration of, these ethical principles. The principles are further outlined in a number of organisational (Policies), professional (E.g. NMC), and legal (E.g. EC Human Rights Act 1989). Although this research meets the key ethical principles, governance of the research is required in healthcare settings to protect the participant's rights. To this end, this research has approval from Coventry University Ethics Committee, see Appendix 7.

What constitutes conducting research ethically has been debated in many fields for over half a century without resolution. The categories to be discussed are beneficence (and non-maleficence), respect for human dignity, and justice, as these are viewed as the guiding principles of medical ethics (Gillon 1994). It is not necessarily the presence or absence of these factors that is the most critical ethical consideration, but it is important to acknowledge ethical considerations, and also balance the risks and benefits of the research (E.g. Gray, Burns and Sutherland 2016). A more precise description of the procedure is contained within the method chapter for each phase of the research.

Beneficence is the duty to act for the benefit of others, and non-malfeasance is the duty to do no harm (Roberts and Dyer 2004). Although it is not anticipated that the participants will directly benefit from this phase of the study, there is a hope that it may be able to assist future incumbents to the role. There is no anticipated harm to the participants, indeed, the submission of a self and supervisor rating for a therapy session in the first term is already a course requirement, so the participants are not inconvenienced by the research.

Occasionally in research, human dignity has not been preserved (e.g. Coolican 2009). The principle of respect for human dignity includes ensuring that the vulnerable participants are protected from harm, that consent is obtained, and privacy and confidentiality are maintained.

All participants in the present study were deemed to not be vulnerable in the context of the research. They are adults working in a professional context, of at least degree level education and have mental capacity. As the researcher is a part time lecturer on the course, the role of a gatekeeper is even more important to ensure that participants do not feel dependent on the researcher, say for future grades. Thus, the gatekeeper collected the consent forms from the participants on each occasion (with the researcher being absent from the room), then received the CTS-rs through the clinical psychology department. They were then coded and passed to the researcher, with the data being anonymous to him, other than data on core professional background, sex, and age group. Even though the data was anonymised, the data was always held on the researcher's person or behind two locked doors to ensure confidentiality of data is preserved.

Participants in all studies have a right to not participate in the study without it affecting their work or training in any way (Barker, Pistrang and Elliott 1994). They also have the right to withdraw from the study at any point without giving a reason. This has been made explicit both verbally, in written form on the participant information sheet, and this understanding is also signed for in the consent form. Unlike when participants are NHS patients, students are assumed to automatically have capacity, and no other approval is needed other than Coventry University Ethics Committee.

There would not appear to be any reason not to allow full disclosure of the study to the participants, therefore full disclosure was given. The only possible drawback of full disclosure is that students may be reluctant to include a marked tape that is of a poor standard for research purposes, however they would also be reluctant to submit the same tape due to receiving a lower mark. Although this is a minor weakness for the study in terms of reliability of the data collected, the researcher does not anticipate that the actual data collected will be influenced by the participants knowing the purpose

of the study. Participants were contacted when the research was completed, where possible, to offer them access to the results of the study.

3.4: Preparation for analysis - Parametric assumptions

The Kolmogorov-Smirnov test is the standard test for parametric distribution criteria. Tests on the 12 categories in both parts (1a and 1b) revealed that the data did not meet parametric assumptions (Table 3.2). However there are a number of weaknesses to this test, two of which are particularly significant to this study. One of these is that the sample size (n=76 total, see Table 3.1 for breakdown) is comparatively small to be able to precisely mimic the said distribution, and also the Kolmororov-Smirnov test performs poorly when the group sizes within the independent variable are of differing sizes (Field 2013). The researcher therefore considered the tests inconclusive and looked within the descriptive and statistical data to try and gather circumstantial evidence concerning whether to use parametric or non-parametric tests. The Shapiro Wilk test was considered as an alternative parametric test, but this test functions poorly when there are high levels of tied scores, as is the case with this sample (Field 2013).

X= Phase of research Y= Parametric test	1a	1b	Comments
Kolmogorov-Smirnov	Significant, indicates not approximating normality	Significant, indicates not approximating normality	Sample size too small to approximate the precise curve even if normality is present
Number of outliers	Rare	Common in most CTS-R domains	
Skewness	1/48 skewed	11/48 skewed	
Kurtosis	No Kurtosis	11/48 have kurtosis	
Homogeneity of Variance	indicates equal patterns of variance between core professions	Indicates unequal patterns of variance between core professions	

Table 3.2: Parametric assumptions tests Phases 1a and 1b

3.4.1: Parametric assumptions Phase 1a

The data distribution for each of the 12 CTS-r domains reveals generally even inter-quartile ranges, low levels of outliers, and means central to the overall distribution. The exceptions to this are 'behaviours' in phase 1a of the research.

Additional evidence about the distribution was taken from the data on Skewness and Kurtosis (Appendix 8). Skewness measures the extent to which the mean represents the central point of the data range, and kurtosis measures the extent of peakedness of the distribution curve, which is related to the spread of variance of scores (e.g. Gray, Grove and Sutherland 2016)). In order to be considered normally distributed, the statistics for skewness and kurtosis are required to be within 2 standard errors ($P<0.05$) (Field 2009). Of the 48 groups tested for skewness and kurtosis (i.e. 4 core professions multiplied by 12 CTS-r items, 47 of the 48 were normal for skewness (Except 'age'nda setting" with counsellors) and all of the 48 items did not have kurtosis.

Therefore, although the data did not meet the criteria for the Kolmogorov-Smirnov test, the size of the sample and the differing group sizes make it an inadequate test and offers a real possibility of a type 2 error (accepting a null hypothesis which is actually false). ANOVA is generally robust to non-normality provided that there are not significantly abnormal features in the data, in particular a significant number of outliers (Schmider, Ziegler, Danay, et al. 2010), which was not the case. Visual data from boxplots, skewness and kurtosis data, and equal homogeneity of variance is suggestive that the data may be broadly functioning normally and be robust to ANOVA.

A decision was therefore made to run parametric and non-parametric tests concurrently on both sets of data, and if very similar results are produced, this would be taken as strong circumstantial evidence that running an ANOVA test, controlling for age and sex, is a legitimate test to run in the circumstances.

3.4.2: Parametric assumptions Phase 1b

Data from part 1b was exposed to a Kolmogovov-Smirnov test to verify whether parametric assumptions could be assumed for this data. The results confirmed a non-parametric distribution overall. As before, a further look into the data to discern some properties is merited. Data on boxplots, skewness and kurtosis, and homogeneity of variance was reviewed. Skewness and kurtosis was inconsistent (37/48 CTS-r items did not have skewness or kurtosis) and homogeneity of variance was not present between the core professions. There were several outliers within the data. Overall, this review reinforced the results of the Kolmogorov-Smirnov test that the data was non-parametric, therefore only non-parametric (Kruskal-Wallis) tests were run with this sample. As there is no ANOVA test equivalent for non-parametric samples, there is no option to control for Age and Sex effect sizes. However, tests for significant differences between the professional groupings and age and sex groupings can be run using Kruskal-Wallis and Mann-Whitney tests, and these are described in the results.

3.4.3: Confounding variables

Consideration was given to the age of the participants being an important confounding variable which should be controlled for covariance if possible. There are two reasons for this. The first of these is that, as noted in chapter 2, life experience, including previous transitions, can impact on future transitions (Brislin 1980), and also may influence some of the more generic relationship based skills in the CTS-r, such as collaboration. The second is that, although this cannot be precisely determined because they are categorised in age groups, a visual scan of the age data reveals that some of the professional groupings have skewed age distributions, for example, counsellors tend to be older than the overall mean, and KSA group members tend to be younger, therefore the impact of age as a source of variance needs to be excluded if differences between professional groupings

are apparent. The categorisation of the age groupings is 25-34, 35-44, and 45-54, representing an even distribution of the overall range.

The researcher also felt it important to control for sex for two reasons. First, traditional perspectives on sex differences in communication have the potential to confound the study, although this gap has narrowed over recent years (see Blum 2005). Secondly, the majority of counsellors are female, so any differences between counsellors and other professions would necessitate further exploration.

3.5: Results

3.5.1: Results for phase 1a – skills differences between core professions

Hypothesis 1: There are significant differences in CBT skills in each individual domain between the core professions

This part of the research is devoted to test the differences in CBT skills between the core professions. A discussion of the normality of the data is contained earlier in this chapter. Briefly, the data failed to meet parametric assumptions of the Kolmogorov-Smirnov test, but limitations of this test due to sample size and non-equal group sizes may explain this. Further circumstantial evidence from box-plot and skewness and kurtosis data suggested that the data may approximate normality (Appendix 8). Although ANOVAs are reasonably robust to non-normality, a decision was made to initially run the parametric and non-parametric tests in parallel, which if similar, would be additional confirmation that ANOVA accurately represents the data, and therefore a multivariate model will be applied. Non-significant results are shown below for visual comparisons between the tests.

Table 3.3: Tests of differences in CBT skills between the core professions, using parametric and non-parametric tests.

CTS-r Item	ANOVA	Kruskal-Wallis	Post Hoc ANOVA
Agenda Setting	<.001 ***	<.001 ***	K>N (P<.001) K>C (P<.001) O>N (P=.009) O>C (P=.011)
Feedback	.002 **	<.001 ***	K>N (P=.007) C>N (P=.001)
Collaboration	.004 **	.003 **	K>N (P=.014) O>N (P=.024)
Pacing and Efficient Use of Time	<.001 ***	<.001 ***	K>N (P=.001) C>N (P=.002)
Interpersonal Effectiveness	<.001 ***	<.001 ***	K>N (P<.001) K>C (P=.048)
Eliciting Appropriate Emotional Expression	.007 **	.003 **	K>N (P=.003)
Eliciting Key Cognitions	.007 **	.003 **	K>N (P=.041) K>C (P=.011)
Eliciting Behaviours	.763 (ns)	.681 (ns)	Not undertaken
Guided Discovery	<.001 ***	<.001	K>N (P<.001) C>N (P<.001)
Conceptual Integration	.037 *	.038 *	K>C (P=.047)
Application of Change Methods	<.001 ***	<.001 ***	K>N (P<.001) K>C (P=.037)
Homework setting	<.001***	<.001 ***	N>C (P=.005) K>C (P=.001) O>C (P=.023)

Legend: N=Mental Health Nursing, C=Counselling and Psychotherapy, K=KSA, O=Occupational Therapy

* p<.05, ** P<.01, *** P<.001, ns=not significant

The results from the parallel ANOVA and Kruskal Wallis tests are identical in significance prediction and very similar in overall significance data. It has already been noted that the skewness and kurtosis data is consistent with parametric assumptions; also a visual scan of boxplot (P-P and Q-Q) data, virtually complete homogeneity of variance and there are very few outliers which are liable to distort the data. This builds a strong case that the data is functioning parametrically, thus justifying a multivariate model to allow covariates to also be analysed. Hypothesis 1 is accepted based on the above evidence, that there are significant differences in CBT skill in these domains between the core professions.

Post-hoc tests are required when the data from an ANOVA is valid and there is one or more significant results. All post hoc tests were conducted using the Bonferroni method. This method is widely accepted as it makes adjustments to reduce the likelihood of a type 1 error that risks occurring due to the large number of tests being conducted.

Multivariate Model (MANCOVA) results for Age, Sex, and Professional background

Given that the data appeared to be functioning according to parametric assumptions, and that the age and sex may be confounding variables (See 3.4.3) a multivariate model was created. A multivariate model is where a number of response variables are modelled jointly, which saves running multiple univariate tests. The purpose of running a multivariate test is to clarify whether other factors, such as age and sex, also explain variations in responses on the CTS-r. The multivariate model is also able to calculate a partial eta squared, that is, the amount of variance in CTS-r scores that can be explained by varying the independent variable, and by varying the covariates one-by-one. It is also possible to calculate whether the partial eta squared is significant in its fit with the model.

Initially CTS-r scores were the dependent variables; the core professions the fixed independent factor, and age (25-34=, 35-44=, and 45-54=) and sex (Male=, Female=) as co-variants. Therefore the model is initially looking to explain the variance across all factors on the CTS-r.

Hypothesis 2: Age is significant in explaining variance in CTS-r scores

The results for the covariant 'age' showed that the partial eta squared was 0.120, or 12% of the variance is explained by the age categories. However this result is not significant, meaning that the raw data is not a good conceptual fit with the predicted model and the hypothesis is rejected. Therefore more detailed enquiry into the specific CTS-R domains will not be pursued further.

Hypothesis 3: Sex is significant in explaining variance in CTS-r scores

The results for the covariant 'sex' showed that the partial eta squared was 0.183.This means that 18.3% of the variance is explained by the 'sex' categories. However these results are not significant, meaning that the raw data is not a good conceptual fit with the predicted model, therefore the hypothesis is rejected and a more detailed enquiry into the specific CTS-R domains will not be pursued further.

Hypothesis 4: Professional background is significant in explaining variance in CTS-r scores

The results for the independent variable 'professional background' in Table 3.4 showed that the partial eta squared was 0.392 (Wilks' Lambda). This means that 39.2 % of the variance in CTS-r scores can be explained by the 'professional background' categories. The result (<0.001) is significant at the p=0.05 level, and suggests a very good conceptual fit with the model, and the hypothesis is accepted. Therefore, the individual elements of the CTS-r will therefore be analysed in more detail to verify their contribution to the variance, and their conceptual fit with the model. Non-significant results are shown below for visual comparisons between the tests.

Table 3.4: Results of Multivariate tests on all CTS-r items

Category	Test	Value	F	Hypothesis DF	Error DF	Sig	Partial eta Squared
Sex	Pillai's Trace	0.183	1.103	12	59	0.375	0.183
	Wilks Lambda	0.817	1.103	12	59	0.375	0.183
Age	Pillai's Trace	0.120	0.671	12	59	0.772	0.120
	Wilks Lambda	0.880	0.671	12	59	0.772	0.120
Prof Background	Pillai's Trace	1.090	2.899	36	183	*<.001	0.363
	Wilks Lambda	0.225	3.195	36	175	*<.001	0.392

It is additionally worth noting with respect to these results, Pillai's trace is relatively robust to non-normality, where this is less so with Wilks' Lambda (Field 2013). The fact that the results of effect size and significance are very similar for both tests provides additional support to the notion that the data is functioning according to parametric assumptions.

Multivariate model results for individual CTS-r domains

Hypothesis 5: Age, Sex and core professional background (independent variable and co-variants) in each individual domain of the CTS-r has a good conceptual fit to the multivariate model

This test is testing the amount of variation in scores for each domain of the CTS-r that is explained by the independent variable and the co-variants in the model. The significance statistic refers to the degree of fit to the model.

The co-variant ‘age’ had almost no effect on the variation in scores for all domains, ranging between <0.001 (Agenda setting and Pacing) to 0.03% Homework Setting. Therefore, between 0 and 3% of the variance in scores could be explained by ‘age’. However, none of the 12 domains had a significant fit to the conceptual model at the P<0.05 level, therefore the hypothesis is rejected and it can be concluded that the covariant ‘age’ does not explain variance in the scores on the CTS-r. The Co-variant ‘sex’ had almost no effect on the variation in scores for all domains, ranging between <0.001 (behaviours) to 0.048 feedback. Therefore, between 0 and 4.8% of the variance in scores could be explained by ‘sex’. However, none of the 12 domains had a significant fit to the conceptual model at the P<0.05 level, therefore Hypothesis 4 is rejected with regard to ‘sex’ and it can be concluded that the covariant ‘sex’ does not explain variance in the scores on the CTS-r.

The results of the multivariate MANCOVA tests for the independent variable “professional background” on the CTS-r scores for each domain is presented in Table 3.5. Ten of the twelve domains demonstrated a variance of over 10% (to a maximum of 34.8% for agenda setting), and had a significant fit to this model. The variables that did not have variances over 10% (behaviours and conceptual integration) also did not have a significant fit to the model. The table suggests that variance in scores on the CTS-r as a result of professional background is of a significant size, and also of a significant fit Therefore Hypothesis 4 is accepted in 10 domains of the CTS-r, excluding ‘behaviours’ and ‘conceptual integration.

Table 3.5: Multivariate tests for individual domains

CTS-r Domain	Mean (SD) Nursing	Mean (SD) Counseling	Mean (SD) KSA	Mean (SD) OT	DF	F	Sig	Partial Eta Squared
Agenda setting	1.982 (0.925)	1.938 (0.793)	3.268 (0.855)	3.400 (1.084)	3	12.476	<.001***	.348
Feedback	2.500 (0.832)	3.438 (0.704)	3.179 (0.641)	3.300 (0.837)	3	4.123	.009**	.150
Pacing	2.907 (0.832)	3.719 (0.631)	3.661 (0.828)	3.600 (0.418)	3	4.944	.004*	.175
Collaboration	2.259 (0.836)	2.438 (0.704)	2.929 (0.801)	3.400 (0.651)	3	5.223	.003**	.183
Interpersonal effectiveness	2.907 (0.821)	3.188 (0.854)	3.804 (0.550)	3.300 (0.447)	3	5.932	.001**	.203
Emotions	2.259 (0.836)	2.844 (0.436)	2.964 (0.693)	3.000 (0.935)	3	3.806	.014*	.140
Cognition	2.463 (0.706)	2.250 (0.458)	3.071 (0.997)	3.200 (0.837)	3	4.245	.008**	.154
Behaviours	2.611 (0.725)	2.469 (0.531)	2.679 (0.863)	2.900 (0.822)	3	.400	ns	.017
Guided discovery	2.185 (0.761)	3.469 (0.884)	3.161 (0.681)	3.000 (0.612)	3	9.576	<.001***	.291
Conceptual integration	2.907 (0.760)	2.313 (0,680)	2.929 (0.703)	2.700 (0.670)	3	1.826	ns	.073
Application of change methods	1.925 (0.817)	2.438 (0.727)	3.125 (0.812)	2.800 (0.274)	3	10.438	<.001***	.309
Homework setting	2.648 (0.551)	1.750 (0.605)	2.750 (1.110)	3.000 (0.612)	3	4.324	.007**	.156

*Legend: * p<.05, ** P<.01, *** P<.001, ns=not significant*

For summary of interpretations of CTS-R scores, see Appendix 3.

Discussion of post hoc results of the skills differences between professions

11 of the 12 ANOVA / Kruskal-Wallis tests were significant (except behaviours, see Table 3.2), with similar significance levels for each item between the parametric and non-parametric tests. This appears to suggest that the data is functioning as parametric, justifying multivariate (MANCOVA) tests. The fact that all except one of the tests revealed significant differences would suggests that professional background is a relevant variable in explaining variance in scores, and requires that post hoc tests are pursued.

A number of themes emerge from the post-hoc tests at the CTS-r domain level, the CTS-r theme level, and overall.

Overall, it is observed in Table 3.4 that mental health nurses performed poorly in these tests, with significantly lower mean scores than at least one core profession's scores in 9 of the domains, with significantly higher scores in only one domain (homework setting), and no difference in the two remaining domains (conceptual integration, behaviours). By contrast, the KSA group received significantly higher scores than at least one other core profession in 11 of the 12 domains, with no incidences of lower scores.

A casual glance over the scores may suggest that the results are surprising. Nurse training includes a general understanding of CBT within its curriculum, most typically within communication skills modules, often with a demonstration of key principles. There is also a relatively strong identification with CBT within nursing, and the term nurse therapist, usually referring to CBT, is often aspirational for mental health nurses. Also Items 2-5, perhaps described as generic counselling skills, are strongly identified with by mental health nurses, and often claimed by professional leaders for nursing identity (NMC 2015).

There would perhaps therefore be an expectation that nursing would "add value", but the results suggest quite the opposite. Phase 2 may help to answer this question further, but one theme

persistently present in the literature is the separation between identification and practice in the nursing profession (e.g. Chan and Rudman 1998). Practice is often technical, medicalised, with an expert role, and risk and emotion averse (Rolfe 2014). All of these processes could interfere with the delivery of CBT. In addition, although the theory and educational principles of CBT is often taught in nursing courses, the practice is not. Regardless of the precise cause, there appears to be aspects of the nursing profession that inhibit the absorption of, or perhaps misinterpret, CBT and generic therapy skills.

Mental health nurses appear to score similar to their peers when the domain has features more in common with the practice of mental health nursing. In particular, these domains are more concrete in their application and more technical in their delivery than the ones where mental health nurses obtained significantly lower marks than their student colleagues. The notion of 'behaviours' is much more concrete as a concept than, say, cognitions or emotions, and also much easier to elicit with less need for more refined therapy skills. The notion of 'conceptual integration' focusing on 2 areas; educating the client (with therapist in a didactic and expert role) and maintaining a client formulation (which also has an educative component) is also concrete, technique based, and in an expert role. 'Homework setting' is perhaps more collaborative in process than 'conceptual Integration' and 'behaviours', but can still be delivered using techniques based on a formula.

Counselling core professionals appeared to have a mixed set of endorsements on the CTS-r, although Table 3.5 notes they generally performed better than mental health nurses (significantly higher scores on 4 occasions and significantly lower on one occasion), however did not perform as well as the KSA group (significant on 5 occasions). 'feedback' and 'pacing and efficient use of time" are generic therapy skills which counsellors would be expected to have some ability in (Gibson, Dollarhide and Moss 2010), and they also are broadly similar in conceptual definition between counselling and CBT meaning of the terms. Feedback refers to the ability to obtain feedback from clients, and also reflect the client's utterances through summarising, which is a valued skill in both

counselling and CBT. The ability to pace the session appropriately is similarly valued, although efficient use of time is not. Counsellors value the ability to be able to respond to client needs in a number of ways, including pacing (Worden 2008). The notion of efficiency in use of time, if it exists at all, would be taken from the client's perspective in counselling, but from the therapist's perspective in CBT.

The domain of Interpersonal Effectiveness elicited unanticipated results for counsellors. The right to practice according to the core conditions of empathy, genuineness, and unconditional positive regard is fiercely protected and identified with by counsellors (Folkes-Skinner 2010). On first glance it would appear surprising that they do not perform as well in this domain, especially when they appear to use their skills well in 'feedback' and 'pacing. Therefore consideration needs to be given to why counsellors perform poorly at 'interpersonal effectiveness'. A possible explanation could be that counsellors perceive CBT as somewhat at odds with the core conditions. Although there is a considerable overlap between the core conditions and interpersonal effectiveness, the greater structure and focus within CBT means that the core conditions, although present in the background, are not the primary focus and are not delivered unconditionally. If counsellors perceive the structuring in CBT as conflicting with the core conditions, they may temporarily stop using the core conditions in order to learn CBT which is perceived as highly structured. Although 'Interpersonal effectiveness' and the core conditions are not mutually exclusive, they may have been perceived as such by the counsellors. Phase 2 of the research clarifies this further.

Discussion – Multivariate Model

The multivariate model confirms the results of the post hoc ANOVA test, (i.e. that there are significant differences between the core domains), but it also identifies that a significant amount of the variance in the scores in this study is explained by varying the core professions, and that this

variance has a significantly good conceptual fit to the model. For the majority of domains between 10-34% of the variance can be explained by varying the core professions. This suggests that the differences between individual scores are significantly influenced by their core profession. These groups have significantly different skills and learning needs, and therefore this has implications for the IAPT / CBT curriculum, particularly in the early stages.

3.5.2: Results phase 1b – Comparison of reflective ability in CBT skills between the core professions.

Discussion of normality of data

In addition to the supervisors' ratings on the student's first CTS-r, the student was also required to complete a self-rating of the same session. This phase of the research seeks to analyse the differences between student and supervisor's ratings, i.e. subtracting the latter rating from the former. This difference may be reflective of the individual student's reflective ability. However, it may be that, if there are significant differences between professional groupings, that these professional groupings create or reinforce attitudes that may be incongruent with the student's actual skills, or that there are significant differences in the reflective ability of each core profession,

The supervisors rating for each CTS-r domain was subtracted from the student's rating from the same domain, transforming the data, with a range of x=-6 to +6. A Kolmogorov-Smirnov test was conducted on the data to assess whether the data met parametric assumptions. The test results were significantly different to a normal distribution. As mentioned earlier, the small sample size and the uneven size of the core professional groupings distorts the likelihood of the hypothesis that parametric assumptions are met occurring. Therefore, the skewness and kurtosis data was analysed. Details of skewness and kurtosis are described in 3.2.2. If the skewness or kurtosis statistic for the above test is within 2 standard errors of the mean, the data is usually assumed to meet parametric

assumptions (Field 2013). Appendix 9 contains this data, a significant proportion of which did not meet parametric assumptions, but this was more widespread across the larger groups (KSA and Nursing) as well as the smaller ones. P-P and Q-Q Boxplots confirmed some skewness and Kurtosis and the presence of significant outliers. Also, 5 of the 12 domains did not exhibit homogeneity of variance on the Levene test. Therefore it was decided that, although there is evidence that the majority of the data meets parametric assumptions, it was not sufficiently widespread across the data and therefore it was decided to assume that the data would not meet parametric assumptions.

Tests of reflective differences.

Hypothesis 6 – There is a difference in the supervisor – supervisee ratings between the core professions in each individual CTS-r domain

An independent samples Kruskal-Wallis test was used to test the null hypothesis that the distribution of differences in each CTS-r category between supervisor and supervisee are the same across different categories of professional background (See Table 3.6). There was a statistically significant difference at the p=0.05 level for Agenda setting (H=19.972, DF=3, Asymp Sign<0.001) , Feedback (H=16.469, DF=3, Asymp sign=0.001), Collaboration (H=24.125, DF=3, Asymp sign<0.001), Interpersonal Effectiveness (H=18.106, DF=3, Asymp sign<0.001), Eliciting Appropriate Emotional Expression (H=17.041, DF=3, Asymp sign=0.001), and Guided Discovery (H=30.368, DF=3, Asymp sign=0.000), therefore the null hypothesis was rejected and the alternative hypothesis that the distribution of the above categories' differences between supervisor and supervisee are not the same across different categories of professional background. All other categories were not significant (see Table 3.6)

Because of the non-parametric nature of the data it has not been possible to control for age and sex in the same way as occurred with the supervisor ratings only. However it is possible to repeat the Kruskal-Wallis test for 'age', and also conduct a Mann-Whitney U test for 'sex' (due to sex only

having 2 categories). The Kruskal-Wallis test for 'age' revealed no significant differences except for 'interpersonal effectiveness' (p=0.046), 'eliciting appropriate emotional expression' (p=0.009) and 'conceptual integration' (p=0.009). The Mann-Whitney U test for 'sex' revealed no significant differences except 'guided discovery' (p=0.004).

Table 3.6: Tests of reflective differences between core professions

Description	Significance	Hypothesis	Post Hoc Mann Whitney	Also Significant
Agenda Setting	P<0.001 ***	Supported	K>C (z=3.403, p=.002) K>N (z=3.078, p=.004)	
Feedback	P=0.002 **	Supported	K>N (z=3.828, p<.001)	
Collaboration	P<0.001 ***	Supported	OT>C (z=3.145, p=.006) K>C (z=4.192, p<.001) N>C (z=2.665, p=.024)	
Pacing	Not Significant	Challenged		
Interpersonal Effectiveness	P<0.001 ***	Supported	OT>C (z=2.445, p=.03) K>C (z=3.555, p=<.001) K>N (z=2.821, p=.015)	Age
Emotions	P=0.001 ***	Supported	OT>C (z=3.157, p=.006) K>C (z=3.242, p=.003) OT>N (z=2.565, p=.03)	Age
Cognitions	Not Significant	Challenged		
Behaviours	Not Significant	Challenged		
Guided Discovery	P<0.001 ***	Supported	OT>N (z=2.905, p=.012) K>N (z=4.060, p<.001) C>N (z=4.067, p<.001)	Sex
Conceptual Integration	Not Significant	Challenged		Age
Application of Change	Not Significant	Challenged		
Homework	Not Significant	Challenged		

*Legend: ***p<=0.001, **, P<-0.01*

Post-hoc tests

With non-parametric tests, it is important to minimise the number of tests conducted as the risk of a type 2 error increases significantly with the number of tests conducted. The method for deciding which post-hoc tests to conduct was undertaken by starting from the highest differences between the means of each core profession's difference in rating, and working down the difference until a non-significant difference is found. The Bonferroni correction is applied, which multiplies the P value by the number of tests conducted. The results are summarised in Table 3.6.

Discussion

One apparent observation is that Items 1-6 are generic concepts not just used in CBT and familiar to all core health professionals, generally valued by them in their core professional training (possibly excepting agenda setting for counsellors), and competence in these areas often reflects a positive core professional identity. The fact that five of these six items have significant differences between the core professions would suggest that these differences are not caused by ignorance of the concepts, especially as the KSA group, the least professionalised group, performed well and the more professionalised groups of counselling and nursing did less well. The CTS-r measures clinical practice in these domains whereas the core professions may only train in knowledge and understanding of these concepts.

Items 7-12 are concepts that are much less common, at least in practice, in the core professions – generally being specific to CBT practice. Although there is much more scope for misunderstanding, this does not appear to be profession specific. On items 1-6, there appears to be a "floor" as to how low professions are prepared to score themselves, regardless of their actual ability. This means that the less able groups are also the worst reflectors as their score clashes with their view of themselves

as a professional. This is not true of items 7-12 where there is less of a core professional identity with the concept.

There appears from the above to be a lack of evidence that the differences are caused by an ignorance of the concepts or an understanding of the practice requirements. The strongest alternative reason for the differences would appear to be either differences in reflective ability between the professions, or an attachment to certain concepts as being consistent with professional identity, regardless of practice.

Overall, both the KSA and occupational therapy had many significantly more accurate scores than their counselling and nursing colleagues and no significantly less accurate ones. Even though counsellors generally exhibited superior supervisor scores compared with nurses, they remained consistently over-confident in their abilities on generic items that they would be expected to understand and identify with from their core professions. The same is also true of mental health nurses.

3.5.3: Phase 1c - Testing the differences between supervisee and supervisor ratings within each core profession

Hypothesis 9 – there is no difference in supervisor and supervisee ratings for each individual core profession

Thus far, the differences have been calculated between supervisors and supervisees ratings, and these differences compared between the core professions. Attention is now turned to whether the supervisors' ratings for each core profession are statistically different to the supervisee's ratings for the same profession.

Results of normality tests using the Kolmogorov-Smirnov test are as can be observed from Appendix 8. Although it could be argued from this data that nursing and KSA mostly meet parametric assumptions for both supervisors and supervisees, it is clear that counselling and occupational therapy are much less consistent in their normality, so non-parametric tests are conducted for comparison purposes. Homogeneity of variance (Using the Levene test) is poor between supervisors and supervisees in all four professions. Therefore differences between supervisor and supervisee could be explained by differences in the homogeneity of data rather than a consistent absolute difference with a homogenous variance. The tests are also described in Table 3.7 below.

A Mann-Whitney U test was conducted to test the hypothesis that the Supervisor and Supervisee ratings were the same for members of the 'nursing' core professional group across the 12 domains of the CTS-r. Results showed significant differences in the domains of agenda setting ($z=-3.150$, $p=0.002$), feedback ($z=-3.008$, $p=0.001$), pacing ($z=-2.129$, $p=0.033$), collaboration ($z=-2.630$, $p=0.009$), Interpersonal effectiveness ($z=-2.874$, $p=0.005$), eliciting appropriate emotional expression ($z=-2.644$, $p=0.008$), guided discovery ($z=-3.070$, $p=0.002$), application of change methods ($z=-2.221$, $p=0.026$), and homework setting ($z=-3.097$, $p=0.001$). The other domains (cognitions, behaviour, and conceptual integration) were not significant.

A Mann-Whitney U test was conducted to test the hypothesis that the supervisor and supervisee ratings were the same for members of the 'counselling' core professional group across the 12 domains of the CTS-r. Results showed significant differences in the domains of agenda setting ($z=-3.122$, $p=0.002$), collaboration ($z=-4.005$, $p<0.001$) interpersonal effectiveness ($z=-3.701$, $p<0.001$), eliciting appropriate emotional expression ($z=-4.038$, $p<0.001$), eliciting cognitions ($z=-2.757$, $p=0.007$), and homework setting ($z=-2.490$, $p=0.019$). The other domains (feedback, pacing, behaviours, guided discovery, conceptual integration, application of change methods) were not significant.

A Mann-Whitney U test was conducted to test the hypothesis that the supervisor and supervisee ratings were the same for members of the 'KSA' core professional group across the 12 domains of the CTS-r. Results showed no significant differences within any of the 12 domains.

A Mann-Whitney U test was conducted to test the hypothesis that the supervisor and supervisee ratings were the same for members of the 'Occupational Therapy' core professional group across the 12 domains of the CTS-r. Results showed no significant differences within any of the 12 domains.

Table 3.7: Tests of comparisons between supervisor and supervisee ratings

	Nursing	Counselling	KSA	OT
Agenda setting	z=-3.150 P=.002**	z=-3.122 p=.002**	z=-0.361 p=ns	z=-0.868 p=ns
Feedback	z=-3.008 p=.003**	z=-0.649 p=ns	z=-0.655 p=ns	z=0.000 p=ns
Pacing	z=-2.129 p=.033*	z=-1.226 p=ns	z=-0.025 p=ns	z=-0.111 p=ns
Collaboration	z=-2.630 p=.009**	z=-4.005 p<.001***	z=-0.660 p=ns	z=-0.108 p=ns
Interpersonal effectiveness	z=-2.874 p=.005**	z=-3.701 p<.001***	z=-0.522 p=ns	z=-0.113 p=ns
Emotions	z=-2.644 p=.008**	z=-4.038 p<.001***	z=-1.441 p=ns	z=-0.430 p=.ns
Cognition	z=-1.515 p=ns	z=-2.757 p=.007**	z=-0.669 p=ns	z=-0.454 p=.ns
Behaviours	z=-1.371 p=ns	z=-0.915 p=ns	z=-0.757 p=ns	z=-0.213 p=.ns
Guided discovery	z=-3.070 p=.002**	z=-0.405 p=ns	z=-0.280 p=ns	z=-0.454 p=.ns
Conceptual integration	z=-1.936 p=.053 (ns)	z=-1.135 p=ns	z=0.737 p=ns	z=-1.063 p=ns
Application_of_change_methods	z=-2.221 p=.026*	z=-0.847 p=ns	z=0.493 p=ns	z=-0.346 p=ns
Homework setting	z=-3.097 p=.002**	z=-2.490 p=.019*	z=1.040 p=ns	z=-0.325 p=ns

Legend: * p<.05, ** P<.01, *** P<.001, ns=not significant

These results confirm that mental health nurses and counsellors appear to struggle to self-assess accurately in certain domains, especially those concepts that they would be expected to understand from their core professions. In part 1a it was observed that the KSA group performed better in supervisor ratings in many areas compared with nursing and counselling. In part 1b it was found that the differences between how mental health nurses and counsellors rated themselves compared with their supervisor was less accurate than their KSA group counterparts in some of the areas where the former performed poorly in part 1a. The third part of the quantitative research confirms that this is because the KSA and Occupational therapy groups appear to self-rate consistently with their supervisors, whereas the Nursing and counselling groups significantly over-rate themselves, mostly in generic skills (feedback, pacing, collaboration, interpersonal effectiveness, etc.).

3.5.4: Summary

It can be noted from the results in phase 1a that there are significant differences between the core professions in all but one domain of the CTS-r, suggesting that core professionals have different levels of skill on entering the profession. Post Hoc tests reveal that mental health nurses, and in some areas, counsellors have a significantly lower level of skill than the KSA group in some areas, with no difference in the remainder. Due to the small numbers in the occupational therapy group, there is inadequate power to achieve significance, although a visual scan of means suggest they perform similarly to the KSA group.

Tests comparing the accuracy of self-rating (1b) between the groups reveal a number of differences between the nursing /counselling groups and the KSA / OT groups in areas of generic skills, skills that participants would all be expected to be familiar with through their core profession or equivalent experience. Results from part 1c confirm that the KSA and OT group report their CBT skills significantly similarly to their supervisors, and that in many domains, especially the more generic

ones, mental health nurses and counsellors over endorse their ability compared with their supervisors.

Therefore there are significant differences between the more professionalised groups, nursing and counselling when compared to the other groups, in accuracy of reporting CBT abilities, and this is due to a poorer ability to accurately self-assess a number of factors which are mostly generic skills. There appears to be a floor below which professionals are not willing to rate themselves, possibly in the context of the fact that, in some areas, mental health nurses and counsellors' report according to their self-perception of their professional identity, not their actual skill. If professional background is significantly different between professions, and professional background initially contaminates some core professions'' ability to accurately reflect in some areas, this justifies knowing how each core profession transitions from their core profession to CBT, and whether the initial differences persist beyond training and cause CBT to be practiced differently. These questions will be researched in phases 2 and 3 of the research in this thesis.

Chapter 4: Phase 2 - How does each core profession transition to and learn CBT?

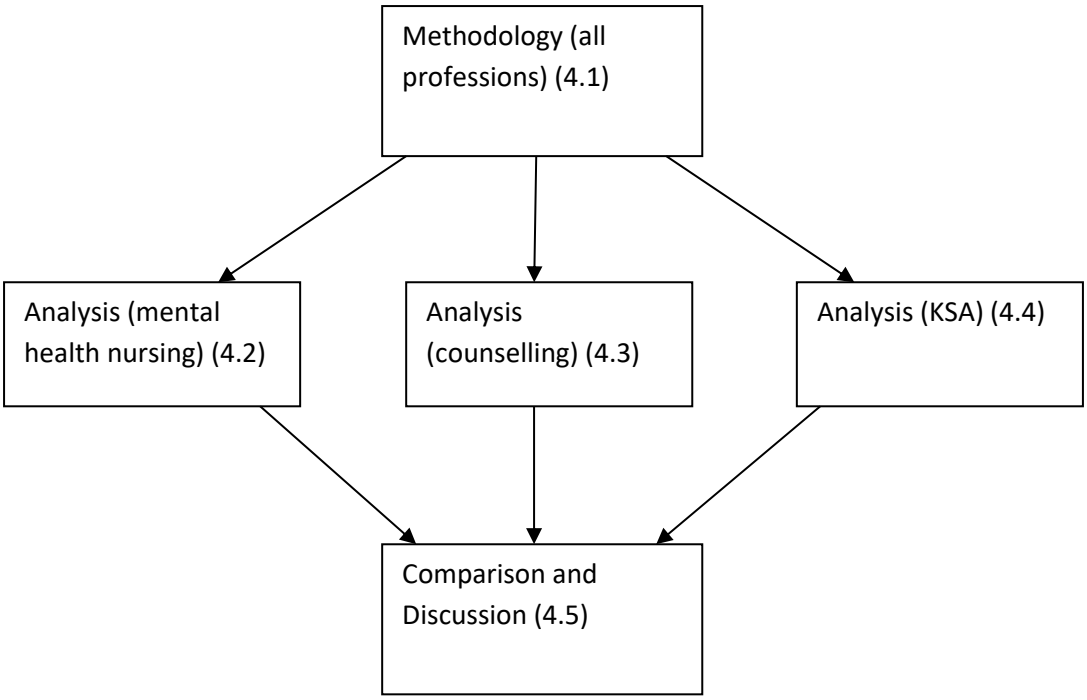
Chapter 4: Phase 2 - How does each core profession transition to and learn CBT?

It was found from phase one of the research that students from different core professional backgrounds start with different levels of CBT skill, and different reflective skills / beliefs about their CBT competence. These different starting points may influence the manner in which the students learn CBT. If this is the case it may have implications for the knowledge base in teaching and supervising student CBT therapists, and for the curriculum of CBT training.

As noted in the literature review (Chapter 2), CBT training places a strong emphasis on reflective competencies throughout the learning process (e.g. Chaddock et al. 2014). In the majority of courses, a learning journal is kept throughout the course, and is formally assessed towards the end. This is typical on similar courses of which the researcher is familiar as an established method of demonstrating accreditation criteria in this area. The assessment criteria of the learning journal will be covered later, however at this stage it is worth noting that it provides an opportunity to observe and analyse the issues in learning and personal development for students in each core profession.

This phase of the study proposes to address how IAPT students from different core professional backgrounds learn CBT, using a grounded theory methodology, and using learning journals from the training course as source data. Each core profession with available data (nursing, counselling, KSA) will be analysed separately, the reason for this is that the purpose of the study is to obtain a theory of learning for each core profession. Analysing the data together would either provide a global theory, or target the analysis to areas of comparison. This risks ignoring novel data critical to a theory of each core profession (Glaser 1992). Comparisons between the groups will be summarised in the discussion, See Figure 4.1.

Figure 4.1: Chapter 4 Format



At present, the vast majority of CBT training courses offer the same process and content of learning regardless of the student's professional background. There is perhaps an assumption made that as students receive the same content of training, they are similar in knowledge, skills and attitudes at the end of the process in terms of their professional practice. There is also an assumption that students from different professional backgrounds experience and process the course content in the same way. This area is under-researched, and casual observation from students undertaking IAPT training would suggest at least some complicating factors in certain core professional groupings, and there is certainly a considerable variation in initial skills and abilities, as demonstrated by part 1 of the research.

4.1: Method

The aim for this phase of research is “To understand the transition process in becoming a CBT therapist”, and the objective is “To develop a theoretical understanding of how each core profession learns and transitions to the role of CBT therapist”. Learning journals from three core professions of nursing, counselling, and KSA will be used as the source material and the written data coded then analysed using a grounded theory (Glaserian) methodology. The number of journals will be determined by the point of data saturation. These core professions will be analysed and reported independently, therefore 3 separate analyses will be undertaken in this phase, one for nursing, one for counselling, and one for the KSA group.

4.1.1: Choice of method

Due to the lack of research in this area, rich, non-reductionist data is needed to describe the overall learning process and answer the research question, therefore a qualitative approach is required. This fits Vaismoradi, Turomen and Bondas’s (2013:398) assertion that “Qualitative research arrives at an understanding from the perspective of those experiencing it”

The choice of qualitative methodologies is typically determined by the nature of the research question, the form of the data, the nature of the information that the researcher is attempting to extract, and the philosophical orientation of the researcher.

As has been noted from chapters 2, the literature pertaining to the research question does not lend itself to a single theoretical perspective. A wide variety of sources and disciplines need to be drawn upon to cover all the issues relevant to the research. Furthermore, there is a paucity of theory and research relating directly to the research question, and therefore much of it has to be drawn from contexts parallel or similar to the students in the IAPT context, including transition, learning, and CBT itself. This suggests the qualitative approach utilised, with a potential for synthesis of theory.

The fact that the data source for this research is in a written form has a significant impact upon the methodology. Some qualitative methodologies focus on how data is communicated rather than what data is communicated. For example, discourse analysis focuses upon aspects of communication such as intonation, speed, emphasis, pauses, silences etc., which is less available in the written word, although the use of bold, underline, and capital letters may partially compensate in this regard. Mehabrian (1971) highlights that speech process accounts for about 38% of verbal communication. Speech process is not available in written conversation, so presumably if people wish to be understood, they need to be clearer with the content in explaining what they mean, and there are incentives to communicate clearly in order to demonstrate learning and pass the assignment, so the written word is a valid source in this case. The lack of opportunity to ask follow-up questions or directing the data process precludes methodologies such as Interpretive Phenomenological Analysis (IPA), which would require more "drilling down" within the interview into lived experience of the participant.

Although limited research has been conducted on learning journals, it is known that they can facilitate learning processes (Brown, Mccrachan, and O'Kane 2011), and predict learning outcomes (Glogger, Schwonke, Holzäpfel, et al. 2012). They are perceived as useful by students undertaking CBT training (Sutton, Townend and Wright 2004)

The focus therefore is on exploration of a process of learning, which lends itself to asking not just to look for themes or descriptors for each core profession, as in thematic analysis, but to explore whether there is a process of learning / adaptation to CBT that is a systemic process and fits with existing theoretical constructs. This lends itself naturally to grounded theory, where categories have an analytical and relational component, not only a descriptive one.

4.1.2: Overview of grounded theory.

Grounded theory is an umbrella term for approaches and guidelines for gathering, synthesising, analysing, and conceptualising data in order to generate theory (Charmaz 2014), The notion that theory can be generated through an inductive process starting from single units of data challenged the prevailing approaches at the time of inception, and has gained acceptance gradually since, particularly when applied to interviews (Birks and Mills 2015), but the application is potentially much broader. It differs significantly from other qualitative approaches in that it has conceptual density and meaningful variation, and goes beyond thick description' (Goulding 2009:384). Grounded theory is widely used across a range of subject areas, especially education and health studies (Thomas and James 2006)

The grounded theory framework used by the researcher in this study is that of Simmons (2008), who uses the idea of preparation, data collection, constant comparative analysis, memoing, and sorting and theoretical outline, which is Glaserian (Glaser 1992) in procedure, consistent with the overarching philosophy. It is recognised that, although broadly sequential, there is an overlap between processes, particularly once analysis has started. For example, memoing may occur in the process of theory generation, and there may be a decision by the researcher to return to comparative analysis to test that theory.

A number of schools of grounded theory orientation have emerged, of which the two most significant exist as a result of a split between founders Glaser and Strauss and a further approach has been developed by Charmaz (2014). Glaser (Glaser and Strauss 1967, Glaser 1998) postulates that the data represents an objective reality for participant and researcher, and all the data should be derived inductively, whereas Corbin and Strauss (2014) argued that a more structured approach should be taken to the analysis, introducing deductive components. Charmaz (2014) and Corbin and Strauss (2014) both take a much more relativist stance, arguing that the participant and the researcher co-create the reality, and the data is viewed from the researcher's relativist position, and

this requires additional exploration in order to overcome researcher bias. The researcher, as already mentioned, has adopted the Glaserian grounded theory methodological approach postulated by Simmons (2008). The lack of direct interaction between participant and researcher limits the validity of Corbin and Strauss's (2014) notion above that the participant and researcher co-create the reality. The participant creates the data, and the researcher interacts with the data rather than the participant.

Corbin and Strauss's (2014) approach to data analysis involves considering all possible interpretations of the data as a stage in intermediate coding before deciding on the interpretation. Glaser (1998), as previously noted, has suggested that this "forces" the data by leading it down invalid paths, which can potentially lead the researcher to infer meanings that are not actually present. Glaser further argues that the original approach remains flexible enough to manage unanticipated interpretations of data (Goulding 2009) and can adjust the direction if necessary (Pidgeon 1996). Melia (1996:376) suggests that "The technical tail is wagging the theoretical dog", leading researchers to search for data rather than observing it objectively. In view of the novelty of this research, it is important that the researcher does not start from preconceptions or inferences that are not present as much as possible, and can incorporate novel or unusual links if so required.

The nature of the data is important in deciding the form of grounded theory methodology. Not only is the data in written form, it is formally assessed by the students' university as part of a portfolio of evidence of learning and development. Although a clear writing style is expected, students are encouraged to adopt more creative and less formal approaches, so the style of writing need not restrict the data. Students are assessed on evidence of learning, not evidence of competence, so students need not be inhibited by fear of negative evaluation, however the focus on learning may lead the students to focus on the more difficult aspects of the training, and underemphasise the more mundane aspects. This is a consistent problem with all qualitative research (E.g. Silverman 2006).

From a “researcher as neutral observer” perspective, the nature of the assignment means that the participant is not only invested in writing what they mean, they are also invested in writing it so that it can be clearly understood by the marker, or someone knowledgeable in the field, and rated consistently. This gives further credence to the fact that there is an “objective reality” within the data to a significant extent.

The research question by its nature also suggests an objective reality (even though the data collection process is subjective). This is assumed by Glaser’s (1998) approach, but not by Strauss’s and Corbin’s (1994). From Glaser’s perspective, the objective reality may be approximated by managing the researcher’s self-awareness of their involvement in the research, and accounting for it through memoing and other methods. The researcher’s experience in this area from a psychotherapeutic background is documented in 4.4**.** Multiple and / or conflicting views of reality on the part of the participant can easily be recorded as “Student simultaneously holds two conflicting views” which is known to be present when people are going through change processes (e.g. Miller and Rollnick 1999). Strauss argues that the reality is relative to the lens through which it is viewed, and the environmental context in which it occurred, requiring additional verification during the analysis process.

One of the main differences between classic grounded theory and a more relativist paradigm is that validation (or verification) of the theory should occur according to Strauss and Corbin, but not necessarily according to Glaser (1992). In this particular study, it would be critical that any cross referencing for validation were to take place close in time to the generation of the data itself as the data is reflective of a changing process and autobiographical recall after the events are known to be distorted by present experiences. This is not realistic as there is a delay between data creation (during the course) and data collection (at the end of the course, up to a year later). To improve the validation, the data was verified through theoretical sampling and by testing the theory by re-

reading the learning journals individually to see if each journal broadly fitted the theory. As this was not possible, this offers further support to not using a constructivist approach.

Constructivist grounded theory, as postulated by Charmaz (2014) and to an extent Corbin and Strauss (2014) argues that the researcher and the participant co-create the reality of the outcomes, which are only valid from a relativist perspective. If this is the case, outcomes are not "theory" in any typical sense, and Glaser notes that the relativist stance of the data analysis and the realist stance of the outcomes conflict ideologically with each other, and is not as grounded theory was originally intended, "adding on" both methodology and ideology.

4.1.3: The researcher's position

The researcher is experienced in the field of IAPT / CBT training, and, although may not be entirely value neutral (e.g. Grafanaki 1996), does not start the research process from a particular theoretical perspective. There are a number of parallel processes between the research and the researcher which are picked up in memos, and described when the researcher places himself in the context of the research. Notably since moving out of nursing to become a therapist, the researcher has moved from a positivist to a freer thinking stance, and grounded theory allows for micro-observation of data, social constructivism, theory development and positivism which allows for a more complete approach that the researcher is seeking personally.

Ideologically the researcher considers himself a free thinker. He generally has a higher tolerance of uncertainty than most, and has a preference for, where possible, observing and describing things as they are. He does not feel a particular need to conceptualise too early within the study, or become overly interpretive. He believes he is open to a range of different options to analyse the data and observing, describing, noticing processes, categorising, and theory generating are all relevant processes and the overlap between quantitative and qualitative also has an appeal as it uses a

relatively complete range of strategies, which assists in the triangulation process. This philosophical stance allows the researcher to "stay with" the data for longer than most, and allow a theory to emerge rather than "forcing" the data to fit any particular theory or approach. This is much more typified by the Glaserian approach. The free thinking approach has been an evolving process for the researcher over about a 15 year timeframe, having initially subscribed to the medicalised view of nursing, albeit with doubts, and has historically held a more positivist paradigm.

There is also an overlap between some aspects of CBT and grounded theory. In particular the process of formulation is very similar, using raw data to create a description of the problem and create a theory of its maintenance. This did have a strong influence on the researcher in training as he found himself skilled in this area, and the approach effective. There is, therefore, a strong congruence between the researcher's philosophical position and the methodology. This approach is the major experiential factor informing his grounded theory approach at the start as he had little experience directly at this point. Understanding the formulation approach is something that the majority of participants will also experience, although it is suspected the impact on them may be more based on personality rather than core professional factors.

The researcher's relationship with the data is further explored in 1.3

4.1.4: Participants

The participants were all students on the Postgraduate Diploma in High Intensity Psychological interventions at Coventry University over seven intakes; 2009-10, 2010-11, 2011-12, 2013, 2014, 2015, and 2016. A total of 122 students completed the course, and were invited to participate in part 2 of the research. Thirty eight participants consented, or 31 % of those invited to do so. Of those consenting, social workers, clinical psychologists and occupational therapists had to be excluded as there were not significant numbers of consenting participants to make the group sizes

viable for research purposes. One participant was also excluded as she was practicing both mental health nursing and counselling immediately prior to the commencement of the course and was excluded on the grounds that the core profession of most significant influence was not clear. It is acknowledged that the research may not apply to those with multiple core professions One participant was excluded because the student had not grasped the nature of the assignment and had written a predominantly academic, as opposed to personal, report, and this piece of work failed and a further learning journal was chosen at random to replace it. Of the remaining 29 participants; 11 were mental health nurses, 8 counsellors, and 10 KSAs.

4.1.5: The Nature of the Data

The data itself is derived from a learning journal, which is a mandatory requirement of the Postgraduate Diploma in Psychological Interventions course that the students are completing. The aim of the coursework is to demonstrate reflective ability, which could cause the students to over-emphasise their learning (E.g. Wills 2007). As one more perceptive student observed

> 'As reflective reports have become more of a requirement in training courses, the purpose of these reflections is to convince trainers and supervisors that the required competencies have been met in order to be a "good" therapist. This seems to indicate that the writing of these reports is not necessarily a neutral process...' K67/2.21-3.1.

Although there is some merit in this, the main aim of assessment in learning journals is not primarily assessment of competence, which is assessed in such measures as the CTS-r. The main aim of the learning journal is to assess learning, reflective skills, and personal development, within which there is no benefit for the student not to be honest about the learning themes although aspects of the learning could be amplified retrospectively, as undertaking learning journals are known to change perspectives (McCrindle and Christensen 1995). This is compensated for by the fact that a reflective

diary helps to structure the students to reflect and record their thoughts on the process relatively close to the events themselves, which prevents retrospective inference of the learning process.

It is worthy of note at this stage that, as the journal was written over a period of 11 months, understandings, meanings, and personal conceptualisations change throughout this period in some key areas, and this needs to be incorporated into the analysis.

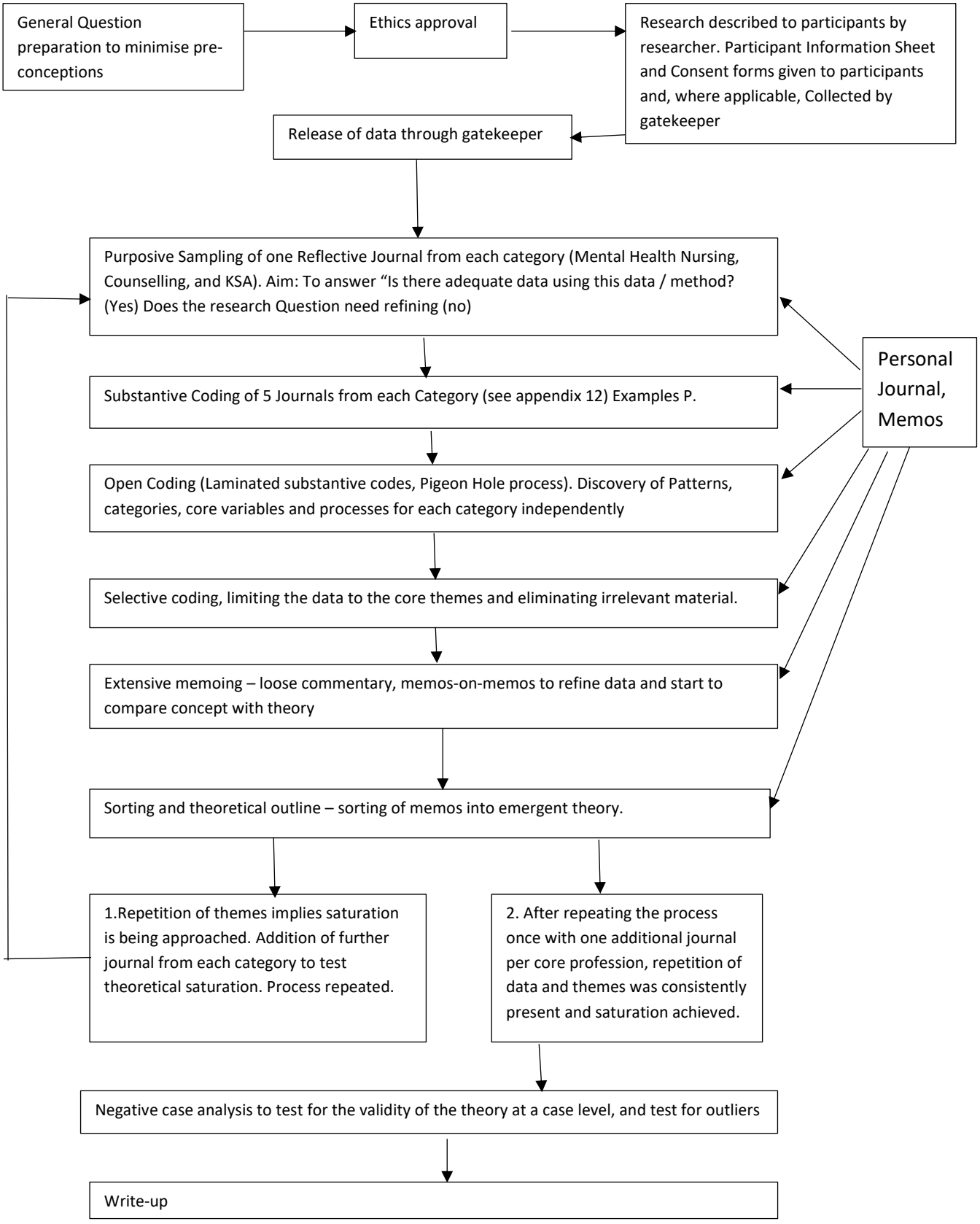
4.1.6: Procedure

A summary of the research procedure is contained in figure 4.2. **Permission to access the participants** was obtained from the course director, and **ethical approval** obtained from Coventry University.

Particular ethical challenges in this phase of research include:

- The necessity of the research. Since the objective evidence base remained limited with this approach, there needed to be a clear rationale for this phase of research. In chapter 1 the issue of ensuring an adherence to the evidence base and the provision of optimum learning opportunities has already been discussed. In addition in this phase of the research, it was apparent that students experience considerable distress, particularly in the early stages of training, and minimising unnecessary difficulties in training and putting support strategies in place that are specific to core professions may have the effect of reducing that distress. Opportunities for support for the students if necessary were included in the Participant Information Sheet.
- There is the possibility that the meaning is misunderstood by the researcher, and because of the nature of the data, there is no opportunity for clarification. However, because the data is an academic piece of work, it is assumed that students are motivated to be understood and the most straightforward interpretation of the data is the valid one. Even when statements

Figure 4.2 – A summary of the grounded theory process in this study



- themselves are ambiguous, context usually offers the most likely interpretation of the data. The researcher noted some poor examples of English, and some metaphors that didn't quite work, but there was no content that was indecipherable or too ambiguous in meaning to use if required.
- There is a possibility that the researcher could become traumatised by the data, in which case support was available within his NHS role. This is unlikely in practice as the researcher has worked in this environment and is familiar with general (but not personal) data.
- There is a possibility that, as the researcher was an occasional lecturer on the course at the time that confidentiality may be broken. This was compensated for by the fact it was a requirement of the assignment that names were not used. Although there was some data which the researcher was familiar with (e.g. trouble obtaining room space in the first intake), none of the data was able to identify the author of the reflective reports.

Students were then approached and had the research explained to them by the course director. Students were reminded that participation was voluntary and that they could withdraw their consent at any time both verbally to the researcher and further details were contacted in the Participant Information Sheet. The learning journals were collected by the course director, who also served as the gatekeeper, who anonymised them, retaining only date from core profession, age range, and sex (e.g. female, 25-35, nurse) and released all of the journals with appropriate consent to the researcher. The core professions were mental health nursing, counselling, and KSA, which are discussed in chapter 2 and defined in chapter 3. Other core professions (occupational therapy, social work, chartered psychologist) did not have sufficient consenting participants and were therefore not included in the study. The age groups (25-34, 35-44, and 45-54) represented the range of the participants (age=25-54). The researcher then chose 7 journals per core profession initially at random, with the intention of taking a further case later if required. In fact, data saturation was established at 7 cases in all core professions. Stratified sampling was undertaken in the nursing

group to ensure that there was at least one nurse who had most recently worked in an inpatient setting and one from an outpatient setting in the data, as all described their previous role in the data. In fact, there were 2 inpatient nurses, 2 crisis team nurses (which contain features of inpatient and outpatient nursing) and 3 community nurses. The data was then subjected to the process of analysis as described below.

Data was "**substantively coded**" according to the procedures suggested by Simmons (2008) and an example of a page of this is provided in appendix 11. Theoretical sampling was initially conducted on one student per core profession, to refine the research question and check the appropriateness of the data. Data analysis was then conducted on the sample of a further five for each core profession (six in total. Open coding was undertaken across the sample that is, describing the data in a way that is as close to the original coding as possible. Data is de-constructed at this stage into units that form the minimum unit for theory construction. The units are described in the form of professional label (e.g. N for nursing) Identification number (e.g. 5), page (e.g. 12), and line(s) (E.g. 11-17) to make up, e.g. N5/12.11-17. We will briefly look at the analysis using the concept of emotions in the nurses section (a subsection of 4.2.3).

Theoretical sampling was conducted at this stage. According to Charmaz (2014) this consists of sampling for theory construction to refine conceptual categories. At this point, one sample from each core profession was analysed initially in order to identify some key core themes, which is intended to assist and make more efficient the subsequent data search in the remainder of the sample. However, no assumption that any sample is representative of a population, or that participants are equal in their ability to generate data, was made. Therefore although the sampling may guide any subsequent search, it does not make any assumptions about the validity of the sample data to the larger sample as a whole. These samples were also given to a supervisor to code in parallel to act as a check of competence and accuracy in the process.

At the preparation stage, it is important, as far as possible, to strive to eliminate and/or minimise the bias of the researcher. To this end, the researcher kept a **personal journal**, as he has a background with CBT and nursing, and has clinically supervised counsellors on a regular basis. An extract from the journal are included in Appendix 10. The aim of the researcher in keeping a journal is that self-awareness of both historical and current factors related to each professional grouping can add to the self-awareness of the researcher, thus minimising bias, and acknowledging it where unavoidable (Charmaz 2014).

The research question at this stage has been deliberately kept broad, to avoid premature reductionism and allow the relevant central themes and processes to emerge from the data. The researcher considers it important that the data is not "forced" too early, and this is consistent with Glaser's view (1998).

Some of the substantive coding required barely any open coding, e.g. "What's going on here? Getting to know people – overwhelmed, anxious and unsettled" (N8/2.4-8) became "feeling, overwhelmed, anxious and unsettled at getting to know people" Incidentally, other grounded theory approaches may undertake moderate levels of interpretation at this point, e.g. "Emotional response to meeting people", but according to traditional Glaserian grounded theory (E.g. Holton, Walsh, et al 2017) this biases the data to the researcher's own interpretation, and eliminates potentially relevant information – for example "overwhelmed" is part of a theme in the counsellors model

However some of the raw data could be more succinctly described e.g. "Formulation / Case conceptualisation: I can say with a degree of certainty that this area has taken longer to grasp than any other conceptual notion in my career, causing me a great deal of frustration N1/12.26-28 became "frustration at failure to grasp concept of formulation".

The substantive coding sheets were laminated (example in Appendix 11), then cut into units and filtered through a pigeon-hole method as way of comparing data with data to establish broad conceptual categories and patterns (**open coding**). These broader concepts were then compared with each other in terms of relationships e.g. causal, symbiotic, independent, alternative, and necessary for, precedes / triggers, sufficient for, etc.

The next stage that the researcher undertook was a process of **selective coding**, comparing concept with concept, to establish more detailed similarities, differences, and relationships. Also, there was a check for meta-themes, that is, features that a range of concepts have in common in order to build up a number of key theoretical concepts. A further aim of selective coding is to eliminate information that does not fit with the core concepts or the research question, so the following example is not considered relevant because it is largely an academic statement of fact and adds nothing to personal reflection:

> "Milne and Macgregor (2007:80) discuss that reflection is a meta-cognitive process, the faculty by which the mind has knowledge of itself". N2/1.22-24

However this statement includes theory and personal reflection, and is coded:

> "... I remember this as a time of sadness and only my inability to give up on anything carried me through. On reflection I recognise aspects of the loss cycle". (Kubler-Ross 1969). C21/8/12-14

A refinement of these concepts, assists with the development of a mid-level theory.

The researcher sorted the data for identical themes in order to identify the most recurrent themes that are likely to be central or critical to the theory, and to start to try and identify the "core theme". Through a process of further refinement of concepts through **memoing**, and comparisons for similarity in both content and process, the concepts were refined until the point of saturation, that is, all relevant data fits with a concept (Birks and Mills 2011)

The memoing themes in this area covered:

· Unanswered questions e.g. “Why is nobody else reporting this?”” Is this fear of negative evaluation?” “Sometimes the emotion is more welcome than others, does this create a separate category?”

· Personal stuff e.g. “I have personal interest in meta-cognitions, do I have a biased filter?”

· Comparisons – Links to other categories (“Saying the same as”, “overlaps with”, “links to”, “not”) are used to place the data in its context, develop an overall model, and refine categories

An example of the latter is that an early category “changing self” was identified, but it ended up being too broad to be functional, and the description of the change, including the emotions category, explained the process in greater detail, incorporating all of the data from the “changing self” category.

An example of the coding at this stage was the raw data:

“Tapes for me were exposure to potential criticism, so in turn very anxiety provoking” N60 was coded as “anxiety and fear of negative evaluation from supervisor, related to tapes” This information was selectively placed into 3 selective coding categories of “overwhelm, emotion and dissonance” and Fear of Negative Evaluation”, and also a later redundant category of “changing self”. These categories were compared with each other for fit and overlap, and further refined. Glaser emphasises the importance of retaining as rich data as possible at this stage, therefore although

“Fear of Negative evaluation”, “Self-perception as incompetent” and “assumptions” appeared to have a considerable overlap with “Fear of Negative Evaluation” and a similar relationship with other categories and could have been collapsed into “Cognitions”, a decision was made to retain the data and integrate these categories if there was an appropriate fit with theory.

It is recommended in grounded theory that the literature review is not written until after analysis (Walls, Parahoo and Henry 2010). However in practice this depends on the nature of the data. For example, it can be difficult to understand what the participant means if there is no understanding of the cultural context, both from a historical perspective and of the culture they are being inducted into. Also, a literature review needed to be conducted on the research undertaken in chapter 3, which needed to occur sequentially before this research. Therefore a minimal overview was conducted with the aim of facilitating the understanding of meaning for the participant, rather than a literature review of the entire subject area. No literature was initially reviewed, for example, in the area of adaptation between groups and cultures.

Once memoing was deemed to be saturated, the process of **sorting and theoretical outline** was undertaken to refine the memos into an emergent theory. A range of theories were considered, which have been reviewed in chapter 2 (Theoretical coding). With “overwhelm, emotion and dissonance”, the dissonance drove the emotional experience according to CBT theory and Cognitive dissonance, and a review of the data confirmed this to be the case. “Overwhelm” consistently fitted within a simpler category of “emotions”, defined within the context of the 5 areas model, therefore the original concept was refined accordingly. “Overwhelm” has a slightly different context for counsellors, being a concept in its own right within a loss framework. Each theoretical concept has moon placed within the context of a model, with inks to the other theoretical concepts.

Negative case evaluation was undertaken. All cases fitted the overall model with the exception of C24 for counsellors, described in 4.3.5.

Initially 6 participants from each group were sampled, with the facility for up to 8. The sampling of the 7th participant provided different examples within categories, but no additional information at the level of category or over-arching theory, therefore it was assumed that saturation had been obtained.

The next stage of the research is the results and discussion section. This is undertaken separately for each core profession in sections 4.2, 4.3, and 4.4.

4.2: Results – Mental Health Nurses

This section summarises the development of seven mental health nurses undertaking the Post Graduate Diploma in High Intensity Psychological Interventions course at a UK university, using a Glaserian grounded theory methodology, as summarised in the 4.1. Of the seven, three had predominantly worked in acute services, one had worked in an eating disorders team, prior to which he had been an inpatient nurse, and three had most recently worked in the community. Inpatient work is usually a "rite of passage" for newly qualified mental health nurses and a number of non-inpatient staff mention experience in this area. Community work mostly involves secondary care clients who tend to be of considerably higher complexity and higher need than the IAPT client base. This student typifies the experience and client base:

> "I work as a Community Psychiatric Nurse. Our clients suffer from a variety of severe and enduring mental health problems. They would rarely be absent from risk and /or functioning severely affected at some point during their time with the CMHT*. ... I certainly have a history in nursing which would constitute experience of the "sharp end" (Previously working in forensic settings, crisis team, crisis day hospital and many other services). N60/1.3-5, 7-9.

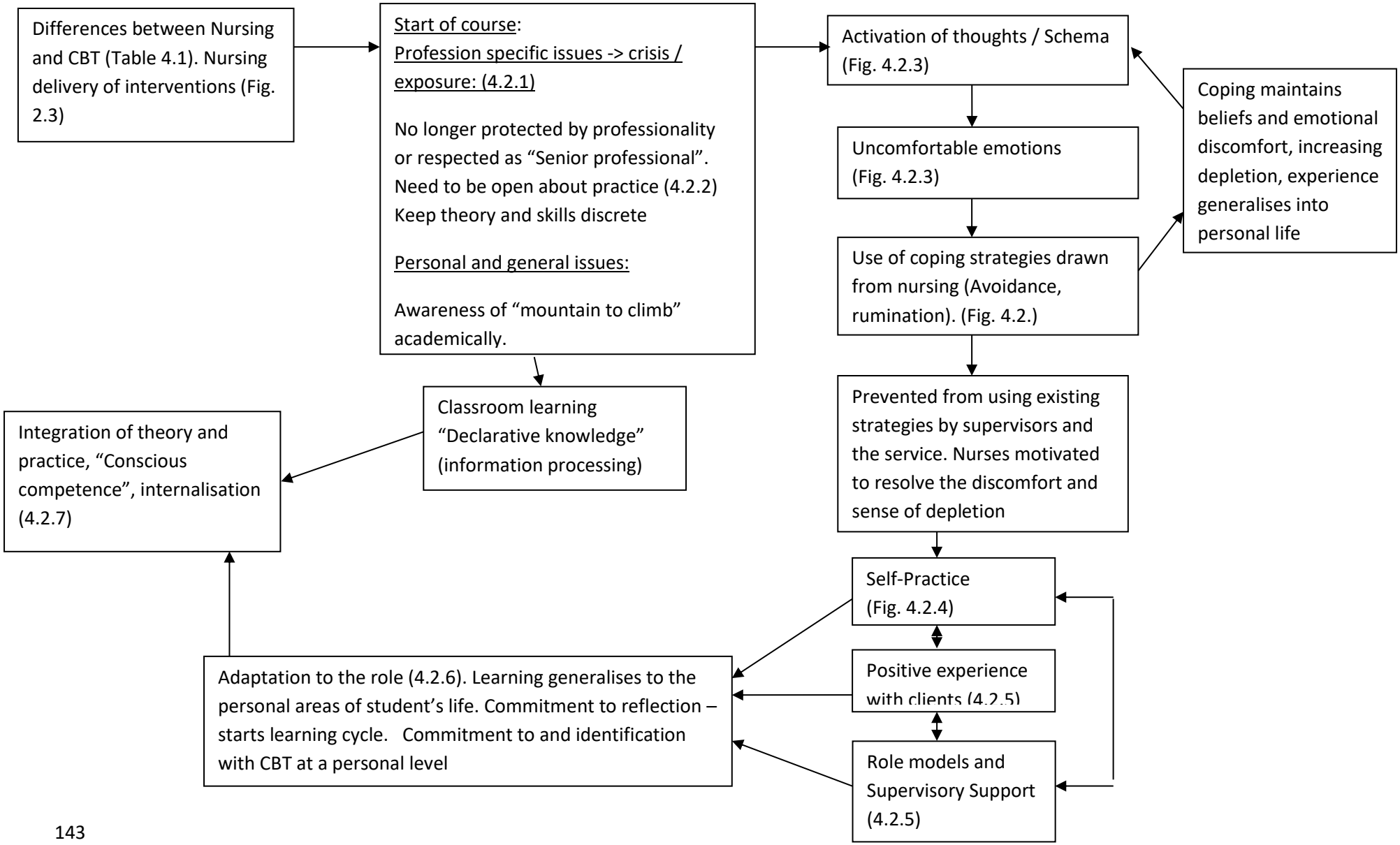
The above quote highlights the emphasis not only on treating high levels of complexity and risk but also the mental health nurses bring into IAPT an expectation in clients of such a level of complexity, and a bias towards searching for it and managing it.

The model of transition as described by the mental health nurses is presented in Figure 4.2 and is based on the themes that emerged from the learning journal data. The model confirms that, although some knowledge is acquired through traditional learning methods (e.g. Baddeley 1997),

the transition process incorporates many features that do not fit with traditional concepts of adult learning, or andragogy (Knowles 1980). In particular, self-as-professional concepts from nursing appear to inhibit learning, as mental health nurses avoid learning in the experiential domain. The model confirms the importance of reflection, but this is initially avoided by mental health nurses, and the process of learning is not explained by the Declarative, Procedural, and Reflective (DPR) model (Bennett-Levy 2006).

Each section of the transition model (themes) is described sequentially through the rest of this chapter. A more detailed description of the emotions and beliefs personally activated for the mental health nurses is contained in Table 4.3, and examples of some of their resolutions in Table 4.4. This process appears to be critical in enabling mental health nurses to overcome factors inhibiting (skills) learning, as will also be shown later.

Figure 4.3: A model of nursing transition to CBT based on the themes emerging from the learning journal data in context of the literature.



Learning is considered to be an on-going process in a professional context, however the model is only intended to represent an approach to the initial training. The endpoint for the majority of mental health nurses is often described as “conscious competence”, a commitment to the practice of CBT skills and of reflective learning, and for most a relatively complete absorption of CBT skills, and shedding of Nursing skills where they conflict with CBT.

Perhaps the best overall summary of this transition process for mental health nurses is articulated by this nurse:

> “... as time went on I found my previous skills getting in the way and preventing me from developing new CBT skills. “ N7/16.18-19.

These skills differences, and the failure by mental health nurses to grasp the extent of the differences initially represent a significant part of the transition that needs to be made. Examples of this are consistently present throughout the mental health nurses learning journals, and examples are contained in Table 4.1

Table 4.1: Comparisons between aspects of Nursing and CBT Practice

Examples of participant quotes	Nursing practice and learning	CBT practice and learning
N12/9.24-28	Task based delivery. Rituals and routines take priority.	Some expectations of tasks but connecting with client less inhibited by tasks
N8/15.5-8 N5/8.2-3	Some ability to use therapeutic relationship and skills, but constrained by psychiatric, management, and peer practices	Therapists expected to combine therapeutic relationship and clinical effectiveness simultaneously.
N1/13.14-18	Emotional containment nurse and therapist	Emotional effectiveness for client and therapist
N2/6.37-40	Emphasis on managing risk	Risk is less dominant
N1/6.2-6	Good practice assessed in positivist way (Completion of tasks done "correctly"), Qualitative practice protected from assessment	All aspects of practice discussed with / observed by supervisor
N1/5.10-12	Role of self not generally considered	Awareness of self and own blind spots important.
N8/3.24-25, 30-38	Some reflection-on-action after events to prevent recurrence of event.	Reflection-in-action and Reflection-on-action both present
N60/12.3-14 N2/8.25-28	Expert role, "Done to"	Collaborative role with some educational / expert aspects. Facilitative role, client is active
N7/15.10-13	Supervision occurs in crisis	Supervision conducted for good self-management and to prevent crises
N2/3.8-10	Assessment medicalised and highly structured	Assessment and case formulation has some structured features and theoretical models, with considerable scope for idiosyncratic approaches within the framework

4.2.1: Differences between CBT and nursing, and the extent of the transition

At the start of the training, mental health nurses see CBT as being compatible with nursing, recognising the educational aspects of it, believing a degree of competence in it, and having an aspirational view of the training (see page 147). Students considered the training to be up-skilling, and in some respects leaving their nursing behind to become a psychotherapist, in others taking on a more senior role in the profession. Some students talked about the "privilege" of being involved with IAPT. This is consistent with research from social psychology showing that high performing members of lower status groups are prepared to dis-identify with that group (Ellemers et al. 1990) and that identity with groups are stronger the more influential they are perceived to be (Van Veelen, Otten and Hansen et al 2010). Professional development is known to be an effective exit strategy for high performing members of low status professions (Crawford, Brown and Majomi 2008) and this is confirmed in the learning journals e.g.:

> "It was good to have passed the interview and it was good to have started the course which was going to enable me to enhance my career prospects in mental health care" N12/5.26-28
>
> "Even before the start of the course, there is a willingness to leave nursing behind, Even though I am no longer "top dog" in nursing" N1/12.10-11.

In spite of a good conceptual fit between nursing and CBT, mental health nurses become aware of a number of features of CBT that surprise them, that they had assumed to know through nursing but didn't understand the nature of the practice. Nursing clearly did not prepare the majority of students for the training, and the literature highlights the fact that nursing has considerable difficulties reconciling the theory – practice gap (Rolfe 1996). A strong contrast between the humanist ideal and the reality of nursing practice evident in the literature review is also evident throughout this chapter.

> "I had used brief psychological approaches such as brief solution focused therapy, motivational interviewing, and cognitive behavioural techniques... I was confident I already had a good grasp of the CBT approach. This was blown out of the water around week 4 of seeing clients". N8/15.3-5, 5-7

The contrasts apparent in the learning journals reinforce the literature in chapter 2 that technical rationality, professionalization, and the medical model are significant influencing factors in nursing practice. Also, examples are evident in the data to confirming the literature suggesting that task discrete work occurs in nursing *in* order to reduce costs and standardise practice (Friedson 2001). For example, formulation and even empathy is viewed as a "technique" initially and this is also evident in therapy. (N60/11.11-16, described in 4.2.1).

In practice this approach is ineffective as the application of a whole model is necessary for good outcomes (Roth and Pilling 2008). The initial contrasts between nursing and CBT in the research confirm that Peplau's (1952) model of nursing remains current in practice. The model emphasises professional knowledge and understanding of the patient as the central principle, but relationships with patients are not, there is greater emotional distance than in the nursing ideals expressed by the Nursing and Midwifery Council (2010). This emotional distance may also help moderate an institution's need for order – idiosyncratic responses and emotional attachments promote diversity and may reduce order (Porter 1993).

The extent of identification between the "professionalised" medical / technical rationality model and the more liberal humanist model does have some variations within the sample of mental health nurses being researched. One student (08) was less "professionalised" in attitude than the others, being more recently qualified and working in the community. This was not true of another Community Psychiatric Nurse (CPN) (02) or nurses that had recently worked in community and inpatient settings (01 and 07) Student 08 was more invested in the principles of a humanist approach than the others and partly carried it out in practice, although was constrained to a certain

extent by the medical model. Therefore, the medical model serves as a constant "pull" back from the aspired humanist approach, and a lens through which mental health nurses initially view CBT.

> "I have had to adjust as a professional to being more 'psychological' in my approach rather than medical" although "this is a transition I have found easy as I did not previously fully align myself within the medical model" N8/16.10-11, 11-12

Evidently, this student had previously practiced a medicalised approach, even though she did not align herself with it in principle. The "easiness" refers to the philosophical adjustment, but in practice she experiences similar transitional difficulties into CBT as the others (such as incompetence, see Table 4.2). One of the researcher's memo's wondered if the technical rationality becomes reinforced or embedded over the career rather than in training, due to an overwhelm of high expressed emotion and distance protects from overwhelm and burnout, but the researcher could see little in the literature to address this. The transitional difficulties experienced by this student included experiencing schema activation during training similar to the others, which suggests that she wasn't strongly self-aware previously and may have been administering humanism according to the technical rationality model. This occurs with the student below, even though she is invested in the ideas of humanist interactions:

> "There is a broad "Rogerian" basis in nursing approaches relating to patients, however nurses are often required to "do to" patients, we use the therapeutic alliance as a necessity to "persuade and negotiate", we portray understanding but often remove or limit choice. We deescalate emotions to minimise risk and increase concordance. We solve problems and give answers. Being able to use rapport in this way for so many years it is no wonder this was difficult to unpick what is different in therapy?" N60/11.11-16

In this statement, there is a very definite emphasis on the pragmatic aspects of nursing emphasising features such as education, an expert role, clear answers and suppression of emotion. Regardless of the intentions of the nurse, the dominance of these aspects in practice bias the use of models to those models that support and / or incorporate them, I.e. the medical and technical rationality

models. The extent of the technique-based nature of nursing, even with the same skills being used, contrasts sharply with the CBT approach, which, although includes a range of techniques and skills within its practice, is driven by an individualised formulation of the client's problems, with interventions based on this. The fact that the practice matches the theory in CBT surprises mental health nurses, who expect to complete the course with limited effort and only partial adherence, largely to objective targets such as coursework:

> My transition from nurse to therapist – which has proven to be significantly more challenging than I may have predicted. Prior to IAPT, I was extremely confident in my clinical skills, and I felt that my existing skills would be immediately transferrable to my new role; after all, it's all the same, isn't it? N1/12.5-8.
>
> Early in the training I seem to believe that "declarative knowledge" will be enough to be told I'm a good therapist. N60/8.10

The expectations above suggest that mental health nurses have been mostly assessed on objective knowledge up to this point in their careers, and expect this to continue. It will be observed shortly that the expected lack of congruency between theory and practice poses difficulties for mental health nurses in their transition to CBT therapist.

The CBT approach holds a positivist position in certain respects, such as an allegiance to a diagnostic model (Hoffman and Reinecke 2010) and the use of randomised control trials to establish an evidence base for both theory and practice (Roth and Fonargy 2013). However, in contrast to nursing, information that does not fit with the CBT theory is not explained away or avoided, but is expected to be explored, consistent with a scientist practitioner model (Townend 2006). Formulation and practice approaches may be highly idiosyncratic if the client does not fit the model, and it may be necessary to work outside the model in some respects, observing what is happening for the client, while still working according to the principles of the model (Kuyken, Padesky and Dudley 2009). Working in less structured formats carries with it risks for both client and therapist (Turpin and Wheeler 2011), which the therapist manages through self-reflection and supervision for

effectiveness and therapist safety, and mandatory course requirements ensures that this happens (e.g. supervision competencies). Given these considerable differences in process between nursing and CBT, it is worth considering how mental health nurses perceive psychological therapies from their nursing experience, as this will filter their expectations of CBT and guide their initial practice.

Mental health nurses experiences of psychological therapies

Given the contrast in practice between nursing and CBT, it is unsurprising that mental health nurses describe their initial experiences of CBT in sharp contrast to nursing. Although there is some previous knowledge of psychological therapies, the experience in practice of psychological therapies and even "talking to patients" provides a sharp contrast to the IAPT course itself. It appears that there is just not a culture of therapeutic interventions in all settings, even if aspired to. Some resistance from colleagues to the provision of therapeutic approaches is described, especially in acute settings:

> "I found the psychological nature of the course and role significantly different from my previous nursing experience" N2/1.26-27 (CPN)
>
> "While I was a psychiatric nurse, psychology or talking therapies was something I did not appreciate a lot then, In my experience of nursing, talking to a patient for a long time as is done in psychology (e.g. 45-60 minutes in CBT) other nurses would be asking you things like 'what are you still doing with that patient'?" N12/7.25-8.1. (Inpatient nurse)

It is also apparent that mental health nurses do not perceive that they have the time to talk to patients. Discrete, task based activities are valued more, interactions are functional and brief, and there is no nursing framework for an intervention of a similar length to a psychological one. This appears to be at least partly driven by the nurses themselves (see N12 above), but there is a strong implication that the organisations do not value long psychological interventions from mental health nurses:

> "Working on a ward with sometimes 15-22 patients with staff ratio of one trained staff nurse and 2-3 nursing assistants per shift in itself would not allow spending too much time talking to one client as there would be too many other things like medication administration and ward rounds to be done". N12/8.1-4.

N12's contribution reinforces both theoretical (Rolfe 2002) and practice (Roskin et al. 1988) literature, which indicates that there is no deliberate attempt to exclude psychological interventions from nursing practice – however there is no framework, time, or opportunity to allow them to occur in any meaningful way.

In addition to global differences between nursing and CBT, nurses identify a number of specific areas where there are specific differences in ideological framework and language, and practice that are of direct relevance to the transition process. The first example of this is **assessment**. Nursing practice strongly allies itself with medical practice in the assessment process, being largely comprised of a structured interview, with some semi-structured features. Most nursing interventions in mental health take place in secondary care, and there is a strong emphasis on identifying with an evidence based diagnosis, and identifying risk, primarily reductionist approaches and concepts (Fourie et al. 2005). By contrast CBT is semi-structured, with questions that may typically be asked, but an expectation on the part of the therapist to explore what is happening for the client outside of such a framework. This is necessary in order to obtain an objective view of the presenting problem, which may fit a diagnostic framework, but would also have idiosyncratic features (Bruch 2015).

At the start of the training, this nurse considered himself to be superior to others in assessment, based on the presumption that it would follow the same, technical-procedural format as nursing:

> "My confidence was boosted when we discussed assessments, risks and making referrals. These were areas I felt confident in... I soon realised and learnt that my experiences and knowledge in secondary care are valuable. N7/5.22-6.3

This confidence was largely at a theoretical level. At a practice level this is much more difficult to implement, as nursing assessment has a different format as described above. A number of nurses have struggled to unlearn their assessment skills:

> "I concluded that my assessment – as suggested in his [supervisor's] feedback – had become focused on information gathering, a style of assessing I had been used to in my previous (nursing) role". N2/3.8-10

There is a clear overlap in terms of language and terminology, but considerable differences in practice. The purpose of assessment appears to be clearer in CBT (i.e. collect adequate information for a formulation), compared with a structured "information gathering" process, as formulation is not a concept commonly used in nursing.

Formulation, or case conceptualisation, as understood from a CBT perspective, e.g. (Kuyken et al 2009), is difficult for some of this group, and a memo notes that it appears to be more difficult the more invested in the nursing (medical) model the nurse is. Guidance and suggested structures are provided based on CBT theory, but there is not a recipe for implementation that mental health nurses are more used to. The need to be responsive to the client and to intuitively know what to do is difficult both to describe and to teach (Persons 2012). The student below is strongly invested in the medical model, but tries very hard to embrace the CBT model:

> "...Case formulation / conceptualisation. I can say with a degree of certainty that this area took me longer to grasp than any other conceptual notion throughout my career, causing me great frustration..." N1.12.26-28.

The frustration experienced by this student appears to be driven by the absence of a parallel concept to formulation in nursing. There is no challenge to the diagnostic framework within nursing of humanist ideas, therefore mental health nurses fall back on the diagnostic framework for assessment and client conceptualisation.

Risk assessment is a concept central to secondary care practice and is identified by mental health nurses as an area of professional skill and competence, and closely allied with professional identity (Aarons and Savisky 2006). It is usually formalised in objective, evidence based tools, usually offering clear recommendations and providing a sense of security and safety for the healthcare professionals (Woods and Kettles 2009).

The IAPT role exists within a primary care setting where risk is less central to the delivery of mental health care. There are some formalised aspects of risk assessment where required, but there is much more emphasis on individualised assessment of risk:

> "... I had previously worked within secondary care mental health services where risk assessment and management were high priority and robust policies and procedures were in place. Such measures gave me a sense of professional security. My thoughts involved the potential consequences of insufficiency or overly assessing risk in a primary care setting" N2/6.37-40

The very structured framework for risk assessment in the secondary care context appears to prevent mistakes when the likelihood of occurrence is higher, and it also appears to have a containing effect on the nurses themselves. The reduced level of risk within IAPT is also confusing, challenging a culture of both certainty and risk aversion in the process of assessment. Potentially it makes redundant a skill that mental health nurses identify and feel confident with. In the new framework, clinical judgement replaces procedural knowledge and mental health nurses struggle to respond to this initially.

A final example of practice conflicts is **clinical supervision** - a concept widely identified with across a range of professional roles in healthcare settings. Although idealised by professional bodies, the practice of clinical supervision varies according to context.

Within IAPT, clinical supervision is seen as a:

> Formal relationship in which there is a contractual agreement that the therapist will present their work with clients in an open and honest way that enables the supervisor to have insight into the way in which the work is being conducted. The purposes of supervision are to ensure safe practice for clients, to optimise client outcomes and to promote greater insight and the development of therapeutic skills for the supervisee. (Turpin and Wheeler 2011:6)

The Nursing and Midwifery Council appear to be familiar with these concepts (Nursing and Midwifery Council 2015), but the learning journals in this study suggest that this is not implemented in practice. New to mental health nurses in particular is the matter of competency assessment, opening one's practice up to others, and discussion of personal processes in supervision (Pretorius 2006). This nurse, who describes having worked in inpatient and community settings, describes supervision very much through the lens of a positivist paradigm in nursing, specifically that it is valued less than other objective skills, it is formal and structured, and is valued in a crisis:

> [Within supervision] "Throughout my training as a mental health nurse, only a cursory mention was given to reflection in the truest sense, the focus being on evaluating ones performance... rather than a more personalised, individual activity."N1/5.16-18, 19

Similar to risk, supervision is predominantly practiced as a procedure, rather than using clinical judgement. It is primarily focused on organisational requirements (e.g. competency assessment) and was more focused on the individual in the context of the role rather than the individual person of the nurse.

This is also evident from mental health nurses practicing across different areas e.g.

> "Coming from a nursing background supervision was something that was talked about a lot but not really done religiously, so having to have supervision twice a week was quite a different experience. N12/9.22-24 (CPN)

> (On Supervision) "in nursing it seems it was something not done religiously as usually, there was always something else to do (e.g. ward rounds, busy ward environment with acute clients, medication rounds, meals to serve, clients on

> different observation levels due to self-harm or suicide risk) and supervision was always cancelled most of the time". N12/9.24-28 (crisis team)

Note that in the last example, task discrete activities are again favoured over ambiguous ones. This appears to change in a crisis when supervision is more valued, confirming the model described in Figure 2.4. This appears to be due to the need to adhere to organisational policies, but also to "patch over" the crisis and reduce the emotional experience for the nurse, supervisor and organisation. The CPN below echoes the first nurse's experience (above), but also adds that she has some anxiety with being open about her practice with others. Idiosyncratic practice requires supervision for safety of practice as discussed, but also exposes mental health nurses to potential negative evaluation, which would not normally occur in nursing:

> "Having had only a few experiences of supervision as a nurse, I was pleased to be informed of having regular supervision during training. Nevertheless I found this quite anxiety provoking when I had to attend group supervision for university, due to the fear of being judged negatively by fellow members or my supervisor" N5/4.25-28

Although this is a personalised response, this nurse voices that they are not used to opening up their practice to others, which is perhaps surprising in a positivist paradigm, as fidelity to the evidence determines the success of the intervention in this paradigm. It may be that because targets are much clearer, for example, doing the medication round correctly, remembering to make a referral, opening up of practice to others is informally "noticed" by others and more qualitative aspects of care are not necessary to assess. However, this appears to be more difficult because the nurse is less able to control subjective aspects of their practice.

Supervision, although identified within mental health nurses, and nursing education, is not regularly practiced, and where it does occur, it is more consistent with management supervision, focusing on role adherence and progression, rather than clinical supervision, consistent with the above definition. By contrast, CBT supervision is more clearly integrated with the profession, involving a

regular reflective process which is more challenging at a personal level for the supervisee, but reported to be more rewarding.

4.2.2: "Professionality" disallowed at the start of course, leading to mental health nurses feeling "exposed"

Having set the scene by highlighting the pre-existing gap between nursing and CBT, the model of nursing transition (Figure 4.2) outlines the stages of training, as mental health nurses are exposed to CBT. There appears to have been an assumption among mental health nurses that CBT could be "bolted on" to existing practice (see 4.2.1), and the IAPT training would not require the changing of nursing practice.

The nursing training and role offers a degree of containment, sometimes sharing accountability in teams and providing considerable structure and guidance for intervention and management of the client and containment for the nurse (Bray 1999). This is in stark contrast to the IAPT role where "professionalism" does not protect the individual, and the mental health nurses struggle with and possibly resent this, e.g.:

> "Having worked closely within a team before as a nurse, I felt apprehensive about managing my own caseload and risk on my own... I began to worry that I would misplace a referral and I felt anxious that I was responsible for so many clients. "
> N5/2.18-19, 20-21

The loss of the expert role and possibly the extent of team support reduces the nurse's ability to protect themselves from emotion, exposing them to emotional experience in their professional role. This containment of emotion in nursing, as previously mentioned, involves technique, but also places the nurse in the role of "expert educator". Mental health nurses conceptualise CBT through this filter, thinking that they "know" CBT.

In previous roles:

> " I had used brief psychological interventions such as brief solution focused therapy, motivational Interviewing, and Cognitive Behavioural techniques, but had not practiced one structured approach... I was confident that I already had a good grasp of the Cognitive Behavioural approach. This was blown out of the water by week 4 of seeing clients!"N8/15.5-8

The attempts to use CBT approaches through a nursing filter with IAPT clients are problematic and ineffective:

> "...as time went on I found my previous skills getting in the way and preventing me from developing new CBT skills. The concept of socratic questioning in particular was proving difficult. The temptation was to offer solutions or options to people especially when working with difficult clients..." N7/16.18-2, see also N1/7.9-11, N1/7.16-20

The nursing paradigm of "expert educator" contrasts with CBT which could perhaps more accurately be described as "collaborative facilitator". The notion of Socratic questioning, mentioned above, is an example of the latter and links with the concept of "guided discovery", as one of the concepts formally assessed in part one of the research. The above descriptions corroborate and explain the fact that mental health nurses performed poorly on the CTS-r item "guided discovery" (using open questions to promote client learning) when initially assessed, and the expectation of initial knowledge explains the mental health nurses over-confidence in the CTS-r self-ratings for guided discovery initially.

There are a number of consequences for the mental health nurses in applying an expert / technique based approach to CBT. An example of this is a tendency to over-control the CBT session. This significantly affects the quality of the therapy, and mental health nurses, clients and supervisors all notice this:

> "I initially felt nervous about technical skills as I wanted to be able to use them correctly. I found that I was using them in a standard, careful way without a lot of flexibility." N5/9.9-10. Patient commented "it seemed as though I was reading a script" N5/9.23

Therefore, attempts to control the session for mental health nurses are not only discouraged at the academic level, but clients also reinforce that this approach, and therefore the nurses are unable to superimpose a nursing approach to CBT.

The expert approach also contains emotion for client and therapist. The student in the first example below reduces the client's emotion by minimising her own emotional expression, and in the second example, "rescues" the client from emotional distress, to prevent emotional expression from the client:

> A further issue feedback from my supervisor related to a deficiency in containing the client's emotion in session and normalising her experience. He commented that my non-verbal communication was a little too 'business like'. N2/2.45-3.1, 3.4-3.6

> I reflected on some previous relationships with clients as a nurse, who demonstrated behaviour that appeared to lack personal responsibility. And where I felt that I had taken on too much responsibility and possibly attempted to 'rescue' them, leaving me feeling tired and frustrated. Although client's mental health had improved, little change in their coping skills had occurred". N2/8/10-14

The second example further highlights that relationships between nurse and client appear to alleviate symptoms, but fail to enable the client to internalise the changes needed to maintain changes in their symptoms.

It appears that the nursing role does not just manage emotions for the client, it has a strong effect on the nurse too. An ability to "remain professional in the nursing role" appears to be championed within the culture of nursing (Hamilton et al. 2004). This presents problems for mental health nurses in this training:

> "I had spent the previous 10 years sweeping many of my own feelings 'under the carpet'" N1/6.11-12

> "... and we often spent time expressing our concerns and frustrations as a small group, as opposed to my previous practice of 'bottling it up' (after all, I was too experienced to show any emotion at work!)" N1/15-18

According to this and other accounts, suppression or avoidance of emotion is practiced in mental health nursing, and this is consistent with the literature (e.g. Bray 1999) which suggests it serves a function of maintaining professionality. This is not permitted in CBT where reflection-on-action is actively encouraged and part of a process of practice based evidence. The effects of this in practice are described in this example:

> "You are too leading", "Let them answer", "Slow the pace down", "Be more socratic", "Pursue answers, don't give up", "too didactic", "be more Socratic", "Try not to explain in CBT terms, this is not feedback", "You are taking too much responsibility for the therapy", "You are working from your agenda". N60/12.16-20

Not only are mental health nurses experiencing a sense of incompetence in CBT, their previous "professionality" inhibits the ability to be open about their practice, and this is exposed in the early stages of training. The need to be open and reflective is critical for CBT development and a mandatory component of the course

The need to be open and reflective about practice

There is no single perspective on reflection, but a relatively inclusive one (describing reflective thinking) is offered by Dewey (1933):

> "Active, persistent and careful consideration of any belief or supposed form of knowledge in the light of the grounds that support it and the further consideration to which it tends" (Dewey 1933; 9).

Self-awareness is considered to be a pre-requisite for reflective practice i.e. the process involves deliberately choosing to reflect through a lens of self-awareness. It is not sufficient that self-

awareness occurs as a product of giving consideration to a situation for that process to be considered as reflective practice (Brockbank and McGill 2007).

Bennett-Levy (2007) describes a broader construct "Personal self – the person of the therapist" as a factor influential in the development of procedural skills in CBT. This construct includes self-awareness, attitudes, interpersonal skills, personal knowledge, and personal experience. The self is not typically part of nursing interactions, this is replaced by professionalism. According to the DPR model, the lack of expressed "personal self" should place mental health nurses at a disadvantage in learning procedural and reflective skills, and this is borne out in this excerpt:

> "[Previously] my post event analysis was strictly clinical and professional, focusing on process and clinical responsibility. I had no experience of reflecting on how certain situations affected me as an individual, nor did I feel that this was necessary." N1/5.10-12

CBT offers a sharp contrast to the lack of the "person in the clinician" in nursing, most notably the role of the therapist and consideration of wider factors, and an understanding of self-awareness which may be labelled as self-reflective ability. Schon (1987) notes that professional curricula are typically based on technical rationality, which he believes is a flawed view of professional competence. However, nursing does identify with reflection and value it in principle.

> "Bulman and Schultz (2004) state that reflection is undoubtedly an important concept in nursing..." N7/3.1

> "Within the nursing profession, learning is deemed a lifelong process. I have embraced this concept but it mainly manifested in short courses and mandatory training". N2/1.25-27

It needs to be borne in mind that the source material of the learning journal is in essence a process of reflection-on-action, a subset of self-reflection. Some students comment upon their initial thoughts about the completion of the journal, noting their reservations about the process:

> "I had the opportunity – moreover, it was actively encouraged - to describe and document how incidents and events affected me as a person, not just as a clinician. I initially found this process particularly difficult... My views around the completion of a learning journal being somewhat superfluous to learning – feeling rather like crying over spilt milk – and I did experience a strong sense of resistance in the early stages" N1/6.8-11, 13-15

The same student describes his new understanding and experience of reflection and contrasts it with his experience of reflection as a mental health nurse. The emphasis on clinical responsibility (accountability) reinforces the view taken by Hoyle and Wallace (2005) that professionalism, with a weaker influence at a managerial level, is better defined currently by accountability and identity as opposed to knowledge or skill. Note that reflection and supervision both have an accountability function in practice. The general attitude of the nurse in terms of a lack of openness ("Therapist attitude" in the DPR model) also holds them back initially:

> "The sense of reflection feeling rather like an evaluative process issue continued throughout my career in inpatient services, with the only time significantly allocated for individual 'reflection' was post traumatic event... the focus was on an evaluation of the process...rather than on how the event had impacted the individual as a whole, not just as a clinician". N1/5.21-23, 24-25, 26-27

In a similar way to supervision reflection is employed within nursing through the filter of task discrete objectives, which probably favours the organisation over the nurse in terms of resolution (See also Figure 2.4). The value of the practice of reflection, even though a familiar concept, takes most of the mental health nurses by surprise. e.g.

> "the results of this [schema] questionnaire highlighted a potential schema of subjugation and self-sacrifice. I was aware of feeling surprised at this and my behaviour / conversations became defensive. When analysing this experience I reflected that this process was alien to me. In my previous role as a nurse, I do not recall being externally required or encouraged to consider my thought processes within a therapeutic relationship, other than to be non-judgemental and treat others equally" N2/7/35-41

The demands of the course, the lack of protection from ritualised professional practice, and the need to manage this by bringing "the self" into awareness, and exposing one's practice to others, appear to make the mental health nurses feel uncontained. As they start to realise that they need to become a therapist, rather than just adopting a role of a therapist, Students are required to be self-aware more of the time. The sense of feeling uncontained spills over into other areas of their lives, for instance the following mental health nurses stated.

> [In nursing] "I prided myself in separating work from home" but now "I was dedicated to the wrong things while my family suffered" N60/7.9, 12-13
>
> "My stress appeared to be well contained at work but when I returned home I found I was easily irritated, worried about time and my ability to perform". N5/13.5-6
>
> (What's going on here)? ...realisation that it is not 'Just a job' and that this training is changing the way I think about my own thoughts and beliefs N8/4.13-17

The effect on other areas of their lives suggest mental health nurses "played a role" in nursing which was not necessarily authentic to themselves, and could be easily separated from themselves. By contrast, CBT requires a "human response" and needs to be integrated with the person of the therapist (Datillio and Hanna 2012).

Thus far many differences noted by mental health nurses comparing CBT with their nursing background have been highlighted, latterly highlighting the lack of stress management skills used or needed by mental health nurses, other than "getting on with it". The IAPT course simultaneously creates stress for the students and expects them to be aware of it in order to improve their therapy, and does not allow them "escape clauses", as they are required to pass practice tapes and expose their practice to supervision. A strong identification with CBT, but a lack of containment as a result of the gap between nursing and CBT and the on-going discomfort this provides, appears to motivate them to search for a way to conceptualise, and later address these issues.

There are a range of different stressors described by the students, some of which are personal, some of which are profession-specific, and some may better be described as universal experiences. One such universal experience is an activation of suppressed thoughts and beliefs about themselves, and similarities in their coping styles.

An example of a personal stressor for one student was a loss of income, leading to not being able to financially support his family in his home country. This was challenged by his family, which led to a clash between African and western values:

> "...This was the most difficult year of my life where some of my family had to ask me to choose between them or doing the course...Working and studying with such family tensions brings its own stress complications... I seriously deliberated to quit at some point during the beginning of the course due to family pressure. " N12/5.22-25, 28-29, 6.1-2

A further example describes a student who was confronted with the need to use information technology, which she had ignored, and she was afraid of being perceived as incompetent. Although this was seemingly less significant than other learning processes, it is typical of stressors unique to the individual:

> "As part of the academic course I needed to build on my limited knowledge of information technology. I had previously been quite reserved in trying new technology and traditionally used books as primary sources of information alongside a journal I subscribed to... I was aware of feeling anxious about attempting using the techniques independently and believed they were out of date. " N2/1.28-31, 35-36

Some universal experiences, also experienced by other professionals undertaking the course (counsellors, social workers, occupational therapists), include having to see clients prior to being competent to practice, learning "on-the-job" and not having a sense of containment. Although a universal experience, nursing has previously provided a professional framework for positivist stances on correct ways to practice, and also permission to contain client or clinician emotion in a variety of

ways that are no longer acceptable in the new way of working. For those students from the first intake of IAPT, a greater lack of systems and procedures, and a requirement to be advocates for the service are also influential. If the new professional grouping (I.e. CBT) does not support the transfer process with resources and supporting the client's emotional needs, adoption of the new grouping by mental health nurses is likely to be considerably weakened (Sims and Veres 1987).

A number of stressful factors appear to be much more profession-specific. Examples of this include loss of role and respect no longer being senior and respected within the profession:

> "Prior to IAPT I was extremely confident in my clinical skills...this view quickly altered when university teaching commenced, and I rapidly realised that I was no longer an expert in my field. I was a novice, surrounded by people with significantly more knowledge than I. This led to a strong sense of uncertainty..."N1/12.7, 8-12

Some mental health nurses are aware from an early stage that they are unexpectedly out of their depth, the term overwhelmed being a repeated theme; others only come to learn about this at the point of their first CTS-r. However, all nurses experience this at some point, and the term conscious incompetence is used on several occasions (Talbot 1993). Until the awareness stage is reached, limited progress towards integration into CBT culture is made in practice, and reflection does not occur. The process of adjustment (Scaife 2001), as well as developing a range of conceptual skills (Grant, Townend, Mills, et al. 2008), can also involve competency shame (Gilbert 2008) especially in being taped and judged on qualitative practice (Grant et al. 2008). When a poor result is unexpected by the student, the effect appears to be worse.

With a large caseload:

> "I initially felt incompetent and very worried about attempting to carry out high intensity CBT interventions on clients when I had not been trained. I also feared the scores from the standardised measures would not reduce, thus clients mental health would not improve, which would suggest I was a poor practitioner" N5/3.3-6

4.2.3: Activation of Schema, emotions, and dysfunctional coping

A structure for management of these difficult experiences is provided by CBT itself. Cognitive Behavioural therapy, as described in Chapter 1, is an evidence-based psychotherapy that is focused on managing emotional distress using a range of techniques that, by changing cognitions and behaviours, lead to the desired change in emotions. The basic model of CBT delineates internal features of a problematic situation into thoughts, feelings, behaviours, and physiological features, all in the context of the environment, described in the Figure 4.4 below:

Figure 4.4: The CBT Five areas model

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(Greenberger and Padesky 2015)

The basic cognitive model attributes an order to the process described above. A problematic situation generates a distorted interpretation by the client, resulting in a problematic emotion. Clients are motivated to reduce their emotions by using a range of strategies such as avoidance, which reduce emotions in the short term, but prevents disconfirmation of the thought.

A summary of examples of stressful situations for the mental health nurses are included in Table 4.2. All the students within the sample describe the situation's effect on the mood, the thoughts activated, and the coping style, which parallels the CBT therapy process for clients, such as that described in Westbrook et al. (2011). The moods described are most commonly associated with anxiety, including being nervous, worried, and overwhelmed.

As noted in the theoretical model (Figure 4.2), a range of different negative automatic thoughts (which are, by definition, involuntary), consistent with those described in the therapy process (e.g. Greenberger and Padesky 2015) are experienced by the mental health nurses. These fall into a limited number of categories, in particular:

Failure to cope (e.g. N5/2)

Defectiveness / incompetence / failure (e.g. N8/3)

Negative judgement from others (e.g. N7/7)

I must get it right / perfect (e.g. N5/9)

The notion of "schemas" at a personal level is regularly used by the students to explain personal distorted perspectives. The concept of a schema, developed in modern psychology by Bartlett (1932) and later Piaget (1992), is a set of rules and expectations which act as a basis for expectancy and recall of information, strongly linked to emotions and behavioural responses. The recognition that these contribute to and maintain emotional disorders, can be altered and affected therapeutically is significant in CBT (Young, Kloso and Weishaar 2003) and part of the IAPT curriculum. Schemas are also used in CBT to look at issues of mismatch / problems in the therapeutic relationship, and are raised by supervisors on several occasions. Mental health nurses retrospectively recognise themes related to their schemas, and appear to identify fairly strongly with the concept.

Table 4.2: Mental health nurses initial crisis experiences on the IAPT course

Situation	Mood	Thought	Dysfunctional coping behaviour	Journal Ref.
Starting job, getting to know people	Overwhelmed, Anxious, unsettled	"Have I done the right thing?" Implied "I've made a mistake"	Thought suppression	N8 / 2
Comparing self to colleagues	Worried	"I can't do this"	Set unrelenting goals	N8 / 3
Listening to self on tape	"sensitive", anxiety	"They won't take me seriously"	Avoidance of taping	N8 / 5
Supervisor provides advice	(Inadequate)	"I'm (Consciously) incompetent"	Avoid supervisor	N8/
Difficulties in supervision	(Vulnerable)	"Supervisor will be critical" "I should be competent by now"	Defensive, protecting Schema	N8/
Expressed emotion in clients	Discomfort	"I must not show vulnerability"	Suppress own emotions Prescriptive practice	N7 / 7
Group Presentation	Anxiety	"They'll see right through me"	Procrastinate, Act excessively confident	N7 / 7
Starting a reflective journal	Discomfort	There's no point	Treat as paper exercise initially	N1 / 6
Having views challenged	Angry, frustrated, Anxious.	("I'm superior")	Act assertively and forcefully	N1 / 9, 10
Practice challenged by supervisor	Anger	"supervisor believes I'm incompetent",	Attack, shift focus onto others	N1 / 11
Someone complements her dedication	Guilt	"I'm not there for my children"	Self-criticism	N60 / 6
Negative CTS-r feedback	Upset, anxious, tearful, irritable	"I'm not good enough" "I'm rubbish ... incompetent, ...unlikable", "	Avoid people, reduce exercise, use alcohol and pain killers, self-attack	N60 / 13, 18
Client activates uncertainty or potential criticism to ability	Discomfort	"I must help", "If I don't get it right I'm not good enough"	"Rescue" clients	N60 / 13-14, 18

It is clear that these thoughts are unexpected by the mental health nurses, and not previously experienced, or if they are, quickly contained at personal and professional levels. Mental health mental health nurses' initial coping strategies described in the tables include avoidance, thought suppression, worry and procrastination, defensiveness, and rigid, over-controlled practice. The effects of these behaviours prevent disconfirmation of the thought, and reinforcing the association between the event and the emotion, increasing the likelihood of recurrence in the same situation (Marks 1987). For example, if you are afraid others will laugh at you during a presentation, then avoiding it will prevent you from finding out that it doesn't occur.

Most nursing students cope initially by using existing nursing coping styles of rumination, avoidance, over-control, complaining / externalisation, or in some cases, helplessness. From a nursing perspective, avoidance and over-control in particular are effective strategies to limit ambiguous information necessary for clear decision making, maintain professionality in the nurse, and maintain a professional distance between nurse and client (Roskin et al. 1988). Rumination, externalisation, and helplessness reflect a lack of ability to deal with high experienced emotion and schemata. Note that this strong attempt to avoid emotion demonstrates that reflection is not occurring yet.

> "Situation / Context: Sensitivity to listening to my voice on tape. Sound of my voice, appraising this "I sound so young, how do clients take me seriously? How did I manage this? Avoidance of taping myself..."N8/5,9-14
>
> "I was advised to hand in a CD that I believed was 'not very good.'. Having done this and spent my week worrying I had carried out therapy incorrectly or even said something inappropriate..." N5/7, 2-4

As already noted, the students at various stages describe a feeling of discomfort, being overwhelmed, and also, for some, drained and depleted**.** It is clear that, initially at least; there is very little reflection-in-action in response to the initial crisis. For some, the initial coping is only problematic when it clashes with the expectations of the supervisor, the academic requirements, or the CBT practice, generating a dissonance that generates a process of reflection-on-action. For

others, the process of dissonance is less obvious; however the process of reflective learning is a fundamental part of the curriculum, so a process of retrospective inference may be present.

At this stage, the students are attempting to manage their emotions with a range of dysfunctional coping strategies (from a CBT perspective). It is evident that mental health nurses are not reflecting at this stage, and critically there is limited awareness of the self, both in and of itself, and in the context of a relationship. There also needs to be an intentionality to the process, a deliberate choice to reflect in order for reflection-in-action to occur (Brockbank and McGill 2007), and this is not present, there is only reflection-on-action.

The theory of operant learning (Skinner 1963) is a natural science approach which at its simplest suggests that behaviours that alter the (internal or external) environment are rewarded (and therefore more likely to be repeated) or aversive (and therefore likely to be reduced (Zimmerman 2001)). Following this theory, the student's negative automatic thoughts generate an uncomfortable feeling which they are motivated to reduce. When dysfunctional coping strategies are prevented by supervisors, the mental health nurses are motivated to search for alternative strategies because, as we have already seen, they are motivated to complete the course.

A range of functional and permissible strategies have been learned on the course are available to the nurses, and the nurses become motivated to try them out in order to reduce their discomfort. This occurs successfully according to a number of conditions, the most important of which is that the subject is confident in carrying out the alternative strategies (Aronson and Carlsmith 1962). Students would not only be motivated to repeat the strategy, but also to self-monitor in order to prevent recurrence. They are learning about self-reflection as a product of self-practice.

> "Tapes in particular for me were exposure to potential criticism, so in turn very anxiety provoking...this has been frustrating and felt de-skilling for me. It seems a development of a therapist's attitude occurred once I was willing to acknowledge my incompetence and dropping of behaviours I was hiding behind, recently I have fully embraced rather than avoided the "reflective system" in the DPR model... N60/8.19-20, 9.2-5

Note that the reflection does not occur spontaneously. A process of acknowledging vulnerability was necessary, which in itself needed to be generated by supervisors, lecturers, and practice tapes. In the example below, being forced to stay with uncomfortable emotions for long enough generates an awareness of the problem which motivates the student to seek resolutions:

> "The fact that my supervisor did not back down ensured that I held on to my unpleasant emotions for significantly longer than I am used to, thus giving me a slightly longer period in which to recognise the way in which I was acting, and view the situation more objectively". N1/11/27-29
>
> "The year of exposure to feedback and criticism has made me more able to accept it and use it constructively" N60/15.7-8

The information processing model of learning is clearly influential in preparing the CBT knowledge although this is actually embedded later through dissonance or reflection (See Chaddock et al 2014). Although reflection appears to be a process that later sustains improvement, knowledge from information processing only appears to occur once there is fuller reflection on practice. This student struggles to integrate theory into practice because reflective practice is not yet embedded in the student:

> "Through reading, lectures and practicing I have expanded my knowledge of the CBT model"... [But in practice] "I often spent more time thinking about the model than thinking about the individual in front of me, which made me feel anxious and uncomfortable". N5/7.24-25, N5/8.2-4

In this example, knowledge is not embedded through classroom learning, because of the lack of a framework for its application in practice, and an inability to understand context and personal factors, which requires reflective practice. There is a desire expressed by some nurses to skip straight to being qualified, suppressing any difficulties until after this point

> "I had thought that I could 'get by' and 'put my head down' and got through it until September" N7/7.46

In summary the drive to engage with CBT fully does not occur spontaneously and is avoided by nurses. The willingness to engage does not initially occur through cognitive or reflective processes, however these processes are stimulated through forced exposure to CBT practice and the ensuing cognitive dissonance.

4.2.4: Resolution in self-practice

The grounded theory model for this sample (Figure 4.2) highlights that the dissonance experienced by the students was not spontaneously resolved, and initially maintained by avoidance and dysfunctional coping. However, when this behaviour was sanctioned, students experience resolution through self-practice. Sometimes the students are encouraged to try CBT techniques on themselves directly by the supervisors, although the mental health nurses tend to do this spontaneously at the point of crisis. Although self-reflection does not initially appear to occur spontaneously with mental health nurses, they appear to, value it once experienced, and apply it as a skill / technique. Initially, reflection only appeared to occur at crisis point even though the knowledge has long been present by this stage. Reflection also occurs later, evaluating a behavioural or cognitive change, or as a result of an unexpected event. It would appear then that self-reflection is a necessary but not sufficient condition in the sample to promote development to a CBT therapist from a nursing role. A number of examples of self-practice are described in Table 4.3.

Table 4.3: Self-practice of CBT by mental health nurses

Description of CBT skills applied to self by mental health nurses	Reference
Lists positives to reduce "negative filter"	N7 / 7.33
Cognitive restructuring	N7 / 7.48, N5 / 6.8-11
Continuums	N7 / 7.11
Behavioural experiment focusing on positive comments	N7 / 7.14
Experimenting with being "imperfect"	N1 / 13
Experiments with acting compassionately and compares with former "professional" self	N1 / 17
Positive data log	N5 / 6.13-15
Challenging, prioritising, graded task / bitesize	N2 / 4.32-34
Dropping of behaviours that are rescuing / avoiding conflict	N2 / 8.5-9.7
Making values less rigid	N12/ 7
Use of self-directed compassion	N5 / 11.1-4
External focus	N5 / 11.16-17
Acted "as if" confident	N7 / 7.17-8.4
Self-reward	N60 / 21
Look after your own needs in balance with others	N60 / 21
Asking for help / reducing avoidance	N60 / 21

A wide range of self-practice techniques are applied by the nurses. Although there is some creativity and personalisation in the design of the practice, the delivery is typically "technique "based, maintaining a process that was present in nursing. Although self-practice is implicitly and explicitly encouraged on the course, it appears to occur without prompting in most of the above examples, which generally occur after initial positive experiences of self-reflection.

Self-reflection is quickly adopted as a habit and generalises quickly once established. Although it appears to be a product rather than a catalyst for progression, it appears to be critical in maintaining and sustaining the role of the CBT therapist (Bennett-levy 2007). A number of students comment on the extent to which self-reflection permeate their lives, e.g.

> "[Anxious, overwhelmed, unsettled]. Through keeping a reflective journal I was able to examine my thoughts, feelings and behaviours, and was able to begin to address these using CBT strategies" N8/18.10-11.

The reason for such a rapid generalisation may be that the rewards are inherent in the practice, personal as well as professional, e.g.

> "...as a result [of reflecting] I feel happier and more relaxed, which has made me more tolerant of others (Friends, colleagues, etc.) and improved my home life". N8/18.1-3.

It is apparent that the earlier deficit of a failure to bring oneself into their professional life is being addressed here. Being authentic, congruent and accepting of themselves enables other areas of their life to also be addressed. This multiplier effect facilitates a rapid learning process through self-reflection.

Earlier, it was highlighted that mental health nurses lack of reflective skills, along with relentless demands of the course activate high levels of emotion and dysfunctional schema, albeit for different reasons in each student. Nurses were able to find some ways to temporarily reduce these emotions, but not deal with them. This is clearly a hurdle they need to overcome, and they lacked the skills to manage this initially. However, they learn a range of CBT skills over the course, and, sometimes with the encouragement of the clinical supervisor and / or lecturers, but often spontaneously, they start applying CBT techniques to themselves. This student attributes early failures to a lack of CBT skills, although there also appears to be a lack of reflective awareness:

> "At this point I was also learning new skills as part of CBT training, and was not able to re-frame this positively at this time. N7/6.3-5.

The student tried a number of techniques on herself. Self-practice generates a refinement in practice, e.g.

> "How I did address this was to apply CBT skills, i.e. thought challenges and weighing up the evidence for the beliefs that 'I would be found out as a failure'" (Challenging filtering negative information) "Weighed up evidence and highlighted positives on the report and CTS-r) N7/7.48, N7/8.24-26.

The different CBT skills applied by the nurses are very diverse in nature, and a sample list is on Table 4.3. The refinement in application occurs quickly, for example, this therapist could have just challenged negative thoughts about what would happen, but became aware that she was filtering information in a biased (negative) way, and chose to list positives to counteract the negative filter.

The effects on the mental health nurses vary from a moderate effect:

> "...weighing up the evidence for my beliefs that 'I would be found out as a failure'. This went some way to address my negative thinking, but reflecting back now, this would been most effective in conjunction with raising my difficulties with my supervisor" (N7/7.48-8.1)

... To a very significant one, where reflective learning generalises beyond the academic and clinical boundaries into the students' personal life, affecting personal values and relationships:

> "Adopting this approach clinically has permeated through the rest of my life, and I feel that I have become significantly more tolerant of situations, people, which would previously have annoyed me. This has been fundamental in allowing me to be more considered and reflective in vivo, in challenging situations. This shift in values and beliefs has been noticed by friends..." (N1/17, 15-19)

Those with moderate effects appear to get sufficient out of the process to be encouraged to persevere. Mental health nurses generally observe that the learning tends to generalise beyond CBT,

as above, and the rewards from this reflection starts and sustains a process of reflection in action, as described in the above example.

The extent of the positive feedback (reflective model), learning (information processing model) or reward (operant learning model) from the self-practice is striking in that it is consistently present in all former nursing students sampled. There is a sense of feeling better, or becoming a better person, (N1/17, above) but also a greater sense of confidence in applying CBT skills, and this encourages mental health nurses to repeat self-practice and invest in the practice of CBT through a reflective process. There also is more of a sense of safety with moderate discomfort and openness to vulnerability:

4.2.5: Positive experiences and support

All students appear to make significant adjustments with their own self-awareness and coping styles, and this parallels an improvement in therapeutic skills. Some of this is attributed to self-reflection, and there also appear to be three other areas that drive these changes: supervision and role-model support, positive experience with clients, and a more deliberate experimenting with CBT on oneself (beyond resolution of discomfort). The three areas described above incorporate a number of learning theories including reflective learning, operant learning and social learning, all of which are deemed important learning theories in change within CBT, and the parallels between student and client are very clear to a CBT therapist reading these journals.

Supervisory support and role models

The clinical supervisor clearly adopts multiple roles within the context of the IAPT training. As far as can be observed from the learning journals, the supervisory role is generally performed well,

prompting further learning, self-reflection and development. The supervisor appears to act as a source of knowledge and skills, at times (but not universally) a confidante, a supporter and encourager, a challenger of problematic practice, an assessor, and a prototypical therapist. Supervision is known to assist socialisation for role newcomers in other areas (e.g. Major, Kozlowski, Chao, and Gardner 1995).

The supervisor as a source of knowledge and skill is quite dramatic at the start of training, often with the supervisor often telling the student how to conduct therapy the following week with each client for considerable time. In addition to the knowledge, students comment that there is a role-modelling, and a containing and stabilising effect. Provision of the necessary resources and emotional needs of the student's leads to a better adaptation to the new role (Turner 1990). The educational component of knowledge and skills training is mentioned less as the course progresses, and this is consistent with how supervision is expected to be conducted within CBT. It is expected that the supervisor performs a more reflective function over time, and that the supervisee is able to internalise the supervisor's questioning for themselves, which also mirrors the therapy process (Padesky 1996)**.**

The supervisor also assesses the student through reports and assessment of practice – a governance role. We have already noted that the process of assessment is difficult for mental health nurses. At times the supervisor needs to correct poor practice of the student. If handled poorly this could have led to disengagement in the supervisory relationship, however most challenges from supervisors prompt reflective learning from the students. This role may also prevent dysfunctional coping, which may prevent learning as described above.

An example of supervisor governance is described when discussing a client with "ostensibly neurodevelopmental" problems inappropriate for the service:

> "I felt I was clinically competent in managing this case", "This was met with an equally forceful rebuttal from my supervisor", "I expressed my dissatisfaction...

> only to be met again with an equally strong reinforcement of the position my supervisor had already outlined... The fact that my supervisor did not back down ensured that I held on to my emotions for significantly longer than I am used to, thus giving me a slightly longer period to recognise the way I was acting, and view the situation much more objectively". (N1/11.9, 13-15, 19-20, 27-30)

There is a power imbalance in the supervisory relationship in terms of the governance role, and this supervisor appears to use this fairly to remain assertive, ensuring ethical practice but give the therapist opportunity to back down gracefully. This leads to change in his practice. Once student's reflective skills are adequate, there appears to be an "exploring alternatives" approach adopted in supervision which would presumably be less threatening for the nurse. Ideally this provides non-threatening conditions for reflection:

> "...novice therapists often need significant guidance in a non-threatening environment where they can be provided with clear, genuine feedback about ways to alter their behaviours in order for them to become more effective therapists. Group and paired supervision has provided me with such conditions for reflection. I have learned the value of testing techniques in therapy, reflecting on and adapting strategies accordingly. (N2/4.4-7)

However, problems were activated by the therapist's own schema on several occasions. The student appears to be rather dependent on the supervisor and any relationship problems between supervisor and supervisee were experienced as significant by the mental health nurses. This student noted that, even though her supervisor was supportive, he was perceived as highly competent, and the student was disappointed that she could not live up to her supervisor's practice – and the skills gap was perceived as too large:

> "Situation / context: Feeling judged and vulnerable. Seeing supervisor as critical parent. Activation of Schema 'I should be competent by now...'" (N8/7.28-32).

The notion of the supervisor as a role model or prototypical practitioner is understood in the broader context of social learning theory, to educate, and reinforce the norms and practices of the

group (Hogg and Van Knippenberg 2003). The fact that the supervisor is able to understand perceived chaos is significant initially (N2/5.31-48), but there is evidence that students also admire the supervisors and wish to emulate them particularly their ability to cope with and use the self, stimulating a desire to learn further:

> "I began to feel inspired by my supervisor as he appeared to be able to understand a variety of client issues from a brief description of their presentation, and his advice helped me to work effectively with clients. I became aware of the depth of his theoretical knowledge and experience which enhanced my motivation to expand my knowledge and continue growing as a Cognitive Behavioural Therapist" (N5/5.10-14).

One student describes the teaching staff as being significant in the completion of the course:

> "... The unrelenting, almost Rogerian support shown by the teaching staff has been instrumental in enhancing my ability to complete a piece of work such as this..."

Role modelling is known to be critical to learning from CBT theory (e.g. Bandura 1977), however this appears to not only be effective in novel learning, but in transitional learning too. Indeed, the lack of appropriate role models from previous nursing roles suggest that it is a necessary condition. Without this, the necessary understanding of theory to practice, and the pastoral support necessary to give mental health nurses sufficient confidence, would not have occurred.

Positive experiences with clients

A further reinforcer for on-going learning and development is the extent of the positive experience with the CBT clients. A number of mental health nurses highlight a positive experience of working with clients as having a significant effect on their development as a therapist. Although therapy appears draining in terms of effort at first, positive experiences of therapy and positive client

feedback are a significant encouragement to mental health nurses, who are not used to making such a difference in a client's life. The first example helped the therapist self-practice:

> "In previous assignments I have identified how particular clients have activated my schema to 'be a good therapist' or do a good job, which increases 'demanding standards .There have been clients I have seen with similar anxieties to myself, and I have been able to draw parallels with my own thoughts, feelings and behaviours with that of my clients, this has increased my therapeutic understanding".N7/15.17-20

> "... It has been an extremely rare occurrence for me to be responsible for a therapeutic intervention which has had such a profound effect on an individual. ... I felt almost euphoric after this session, and it was at this precise moment that everything I had learned within IAPT merged with my existing clinical skills, removing my previous notion that these two areas should remain forever discrete" N1/ 14.22-24, 25-27

The above description highlights a relatively permanent change for the therapist as current knowledge, past experience, and the person of the therapist are no longer discrete concepts, and, as they are now integrated into a whole, they can no longer be ignored or avoided. This appears to have been driven by the reward for the nurse in positively affecting someone's life so profoundly (experienced as uncommon in nursing, see above), seemingly by a form of operant conditioning – reward from an intervention leads to a commitment to repeating that intervention.

4.2.6: Adaptation to therapist role

With increasing confidence in knowledge and skills in CBT, and positive experiences of it, mental health nurses start to adapt to the therapist role. Although it is clear that there is a considerable degree of adaptation to the IAPT role, consideration needs to be given to its overall extent in specific domains. Brislin (1980) describes a number of different possibilities in adapting to cultural change;

specifically non-adaptation, substitution, addition, synthesis, and re-synthesis. Adaptation is consistently present in identification with CBT from the start and mental health nurses are ready to be absorbed into the role, and shed nursing behaviours where necessary. Supervision, although difficult for some, is largely adopted and engaged with, in spite of the concerns opening up one's practice to others, the mental health nurses invest in the process and benefit from the support. The same is also true of self-practice and client work, and there is evidence that the mental health nurses go beyond the minimum requirements and invest in both the idea and practice of CBT.

It is difficult to be sure about whether there are any areas where adaptation does not take place from this phase of the research, but this is addressed in phase 3 of the research. Turner (1990) suggests that some features not described in the journals influencing adaptation are: Structural integrity of role (extent to which they can practice independently, client demand, cultural integrity and legal support), all of which are relatively high for the IAPT high Intensity role at the time of the research. Bennett-levy (2007) also adds that it is important to identify "self-as therapist" - this is indirectly present in a number of scripts, but this student mentions it directly as important in maintaining and consolidating her knowledge and skills gains:

> "I am mindful of my 'virtuous self' and 'self-in-therapist-role' in ensuring this sense of awareness of learning achieved remains and flourishes'. N60/16.2-4

Also, although the mental health nurses have demonstrated adaptation, it is known that they relapse to medical practice under condit7ons of stress, or if they don't know what to do (Hamilton et al. 2004). One student describes lapsing back into nursing over the summer break:

> "During this time there was a stint of isolation from university, supervision and peer support so I retreated to what I knew best – I was being a good nurse! However mid-to-end course my CTS-r scores got worse! And then I failed one... The outcome of [dialogue with my supervisor] was that I possibly make clients dependent on me" N60/13.3-6, 9-10

There are also other aspects of nursing practice such as risk management, procedural skills (e.g. managing referrals and discharges, assessments) that have been relatively unchallenged by IAPT, although do need adapting from the nursing role. Initial screening / triage of clients has become very procedural in IAPT, and the extent to which mental health nurses invest in technical skills is unclear. Nurses do sometimes describe reflection and similar skills as "techniques", and part 3 will assess whether the improvement is observed through a fragile, technique based lens.

A memo taken from the process of coding the data notes that nursing students include literature about reflection at this point. This may bias their attributions about what is happening to them to the literature rather than true reflection-on action.

Almost all students acknowledge the process of reflection as critical to their development, and show a commitment to maintaining it. Some comment on the affect that it has had in changing pre-existing difficulties, others simply notice that the process has been more effective in making them a better person

4.2.7: Integration of theory and practice

There are some fairly dramatic "light bulb" moments of awareness which motivate change described by the students, for example:

> "I was comparing myself to colleagues and peers, and struggling to cope with my issues and schema that was being activated. I was comfortable within my previous role which centred around 'helping others' without much focus on my responses and the interpersonal processes occurring. This was a light bulb moment' for me in this course, I became aware of my tendency to 'rescue' and my desire to 'fix' my clients" N8/18.13-17

These moments motivate greater engagement with the process of learning experientially. The theory of CBT, reflective learning, and awareness of self appears to come together simultaneously for the first time.

Theoretical understanding normally precedes practical understanding with mental health nurses. Moments of awareness through practice are often precipitated by a requirement to consider alternatives as they are no longer permitted to use existing coping strategies, or they become aware that they will fail the course if they continue their current practice. Once reflection-on-action starts to occur, the important aspects of CBT theory, which is understood by the students by this point, starts to integrate with practice. This appears to not be a common experience for mental health nurses previously...

> "...my new ability to reflect critically on my experience and to integrate experience with knowledge I possess, and to take action on my insights..." N12/13.12-14
>
> "Reflection has taught me to blend learning through experience with theoretical and technical training to form new knowledge constructions and new behavioural insights..." N12/13.3-5

One aspect of the learning towards the end of the training that suggests that learning gains may be relatively permanent is the extent that, unlike the nursing "role", CBT and reflection / self-awareness appears to be voluntarily adopted as a life philosophy, with on-going positive results:

> "This report has led to me reflecting a great deal on my life in general, not just which is defined by the university set parameters, and this has proven to be an enlightening experience, resulting in a number of significant positive changes". N1/18.6-8
>
> "I felt that the enhanced reflective skills I have gained through this process are transferrable to other areas of life, and I am better equipped to address my own issues" N8/19.6-7

The mental health nurses appeared to indicate that this experience can't be unlearned, and believed it to be a relatively permanent change, both in behaviour but also in its ensuing identity. For example, recognition of a need to self-nurture is also adopted as part of the above philosophy, which, in absence of the distancing effect in nursing described in 4.2.1, substitutes as a protective effect for the new therapists:

> "During this year I have become aware of the impact of failing to self-nurture" N2/8.41-45

> "The above [client case] example taught me the importance of self-care" N7/11.6

A number of the students described the joy of the experience, and how difficulties and adversity had helped them develop and strengthened relationships:

> "The university course is something in which I have gained more of a sense of fulfilment and achievement than anything else in my career, and I feel a sense of sadness that it is almost over". N1/18/14-15

> "I have developed strong bonds with individuals from a remarkably wide range of different clinical, academic, and cultural environments, often in the face of adversity. N1/18.15-17

> "The friends gained, lecturers, supervisors and clients, have all made this an incredibly worthwhile journey" N60/16.7-8

The overcoming of adversity and the difficulty in transition appears not just to have generalised as a positive experience, but also embedded the CBT identity. It suggests previous research suggesting investment in a role correlates with the strength of identification with it (Eaton and Lasny1978).

4.2.8: Final positions

At the time of completing training, the majority of trainees were "consciously competent" examples of unconscious applications of skill are rare at this stage. There may be a small amount of non-adaptation, but there is generally a mixture of substitution and synthesis in favour of the new profession (CBT). It would certainly seem that the aspects that are embedded are relatively robust and sustainable from the practices put in place in chapter 5. Here is an example of at least partial synthesis:

> "Throughout the year I have begun to follow a protocol in my own way and in a way that is responsive to the needs of the client" N5/9.2-3

Note that the emphasis on protocols ("how to") is very much maintained from the technical rationality approach and process within nursing, even with a degree of personalisation.

There is a universal acknowledgement from the students that their learning is not yet complete, and there is also a commitment to future development, e.g.

> "I spend brief moments in conscious competence by this stage (and my latest CTS-r feedback reflects this) but there is not enough time to consolidate and grow" N60/16.1-2

4.2.9: Discussion

The objective of this research is to develop a theoretical understanding of how each core profession learns and transitions to CBT, and this section describes a grounded theory analysis of the learning journeys of seven mental health nurses training to be IAPT (CBT) therapists. Figure 4.2 presents a model that summarises the process of their development. The many differences between the nursing and CBT professions in practice, and also contradictions within the nursing profession, are highlighted. These conflicts cause a degree of stress and discomfort which all the mental health nurses interviewed attempt to avoid initially. Required to practice CBT and face their fears, they

described finding a range of solutions from within CBT itself, and they also experience benefits in self-practice of CBT and of reflective practice. They experiment with reflection, and reflective skills and self-awareness generalise throughout the students' practice and lives rapidly. Facing up to issues, they have positive experiences of therapy, and experience professional and personal support and role-modelling, especially from supervisors. The changes appear relatively embedded.

One of the features not consistent with the DPR model is the fact that mental health nurses initially avoid resolution of stress, or manage it in such a way that the problem is maintained. This comes from both the "therapist attitude", and a lack of a "personal self" in professional relationships, and probably difficulties with "interpersonal perceptual skills" affecting reflective and procedural learning. They do not spontaneously adopt CBT and reflective practices in the early stages of training even though the knowledge is present by his stage. It appears that the option of avoidance is prevented from features such as supervision, observed tapes, and an academic requirement for reflection. A number of mental health nurses hoped to fake their way through, relying on declarative knowledge only. However, faced with on-going stress and with formed dysfunctional coping disallowed by the training, students are motivated to search for alternative coping. The effect of the conflict in both the content and process of learning between the nursing and CBT professions, and a motivational aspect in 'kick starting' the reflective learning process in CBT has not been written about before to the researcher's knowledge. Ideally and perhaps typically, knowledge and skills are learned simultaneously in CBT. However, in nursing there is a fairly significant period of separation before knowledge and skills are integrated.

A constant theme that arose from the analysis of the data was is the initial "professionality" and "self-distancing" of mental health nurses, reinforced by the profession's task-discrete approach to care delivery, regardless of the nurse's underlying philosophy. This contrasts with a reflective and self-aware group of mental health nurses by the end of the programme. When self-distancing is disallowed by the course, stress and crisis ensues. When self-awareness and reflection is attained,

the nurse appears to attain a happier state of equilibrium. Self-distancing is substituted for self-awareness, self-practice and reflection by the nurses as a way of coping with personal difficulties in a professional context. This student perhaps sums it up:

> "Beck et al (1990) suggest that "To manage the limits of the therapeutic relationship effectively. And to use their personal reactions in the process of treatment, Cognitive therapists must first be sensitive observers of their own thoughts, feelings and beliefs". This time last year I would have considered this view to be somewhat in conflict with the realities of clinical practice, best suited to remain as an ideal citation for an unreachable aspiration. Today, however, I feel this concept is fundamental to the way I practice, and I believe that it is this polar shift in my viewpoint which encapsulates my personal and professional growth" N1/18/22-29.

4.3: Results - Counselling

As demonstrated in 4.2, the complexity of the transition to practicing CBT can be understood in the light of professional background and coping strategies in the case of mental health nurses. Certain differences however, can be identified across disciplines in the same field. This section focuses on the experience of counsellors transitioning to the use of CBT. Williams' (2008) 5 stage model has a strong theoretical fit to this group, which incorporates concepts such as loss not experienced by other core professions. Some minor revisions are made in the light of the counsellors' endorsements in the data. The results demonstrate significant ideological conflicts between counselling and CBT.

The counselling and psychotherapy group (hereafter counselling or counsellors), as previously defined, are registered practitioners with the British Association of Counselling and Psychotherapy (BACP) or the United Kingdom Council for Psychotherapy (UKCP). Unlike the nursing core profession, which has a relatively standardised training programme, accreditation with the above organisations is based on a range of minimum competencies that can be achieved through quite a wide range of training, including core training in one of several psychotherapies (person centred, psychodynamic, CBT), or a combination of them. Typically these practitioners are practicing in primary care counselling, private practice, or the third (charity) sector.

Of the 7 counsellors in the study, 6 were females and 1 male; this is relatively representative of the counsellor population as a whole (see Dalziel 2009). One counsellor was in the 25-34 age group, 3 in the 45-54 group and 3 in the 35-44 group. There was no requirement to state therapeutic orientation, but one counsellor said that historically their primary therapeutic orientation was psychodynamic, another two considered themselves to be primarily person-centred in orientation. All seven identified that they used strategies from a range of different therapeutic orientations, including CBT, and this is particularly significant in this chapter, as the right to practice a wide range of skills from different backgrounds is important to counsellor identity (see above) and contrasts sharply with CBT as discussed later in this chapter.

4.3.1: Key literature on counselling features

There are, however, some important themes that are consistently present in counselling training. One is that the therapeutic relationship is considered central to improvement in the client, and is generally viewed as a sufficient and a necessary condition for client change. This contrasts with the CBT perspective that the therapeutic relationship is important, but other factors including structured features are important, and the therapeutic relationship is considered a necessary, but not a sufficient, condition for change (Macneil, Hasty, Evans, et al. 2008). There is agreement that it is a process that occurs between a practitioner and client that generally has a curative effect (McCabe and Priebe 2004), but the constituents and the effects are debated (Norcross, Evans and Ellis 2010), for example counselling generally emphasises client-centeredness in the relationship, where CBT emphasises collaboration. This predominantly constitutes professional marketing and emphasis, as different psychotherapists express similar levels of empathy (Keijesers, Schaap. And Hoogduin 2000), although it is likely to affect counsellors expectations in training in CBT (Kennedy-Merrick, Haarhoff, Stenhouse, et al. 2008).

Two other factors feature strongly within counsellor training, which are especially relevant for this chapter. The first is the role of awareness of the self in counselling practice (e.g. Lennie 2007). Counsellors are encouraged to consider and emphasise their own role in the therapeutic process and their own motivations and drives within their counselling practice generally and both self-reflection and personal therapy are present in trainings and a requirement for accreditation. Cultural concepts within counselling include the notion of a counsellor's shadow (From Jung 2014) and the notion of a counsellor as a wounded healer (see Wheeler 2007) that have been through similar processes themselves, pervade the profession. Thus, there is a degree of placing themselves in a vulnerable position, which probably is of relevance in their learning journey, perhaps amplifying the emotional effects. This affects choice of profession, see 2.4.

A further concept that is apparent is that the fact that counselling is not especially professionalised in the respect that there is a strong identification with roles, rituals, or theoretical concepts. There is not homogeneity or cohesiveness to precisely what is practiced, and what similarities there are not defended or protected by counsellors. However, the right to practice independently and autonomously, being responsive to the client's needs, is vigorously defended, which is a theme throughout this chapter. Therefore, one of the most consistent features of the group that is protected is an "anti-professional" one. The right to practice independently and autonomously appears to be related to be the need to be client-led and responsive to the needs of the client:

> "Respect for client autonomy is a high priority in most approaches to counselling. Without a respect for client autonomy or self-determination, counselling would become an ethically compromised and potentially self-diminishing activity for clients." (Bond 2015:85)

Conflicts of ideology and practice exacerbate a transition gap, which is difficult to manage for the counsellors. An unanticipated disallowing of counselling practice generates a strong sense of loss, which is a consistent theme, and a basis for the theoretical model. This issue is not specific to CBT, counsellors transitioning to psychodynamic practice have similar issues with adherence to the new model (Mackay, West, Moorey, et al. 2000).

4.3.2: Theoretical framework and model – Loss and transition

Loss is an important concept within a counselling framework, and can be applied to a wide range of therapeutic situations for the client (Worden 2008). Associated with this concept is the idea of a grieving process (Kubler-Ross 1969), and current models of loss in counselling continue to be based on this process. According to Adams, Hayes and Hopson's model (1976) people pass through a number of stages during loss in the process of adjusting to it. These stages are denial, anger, bargaining, depression and adjustment. The concept is largely absent from CBT, and features of loss

would typically be absorbed within diagnostic categories such as depression, but this is changing (Morris 2008). There have been multiple adaptations of both loss and transition models since (Parker and Lewis1981, Bridges 2009, Williams 2008). The variations from the existing model proposed include an initial experience of loss, active strategies to maintain the honeymoon period (such as minimising), the crisis period coinciding with a sense of overwhelm (driven by inner contradictions), and the use of self-experience as an adjustment strategy. The original transition model is a good fit with the process of learning as described by counsellors in the current study and shown in Figure 4.5, and the revised model is presented in Figure 4.6, below.

Figure 4.5: A theoretical model of counsellors' transition to CBT (Acknowledgements: Adams, Hayes and Hopson 1976, Williams 2008),

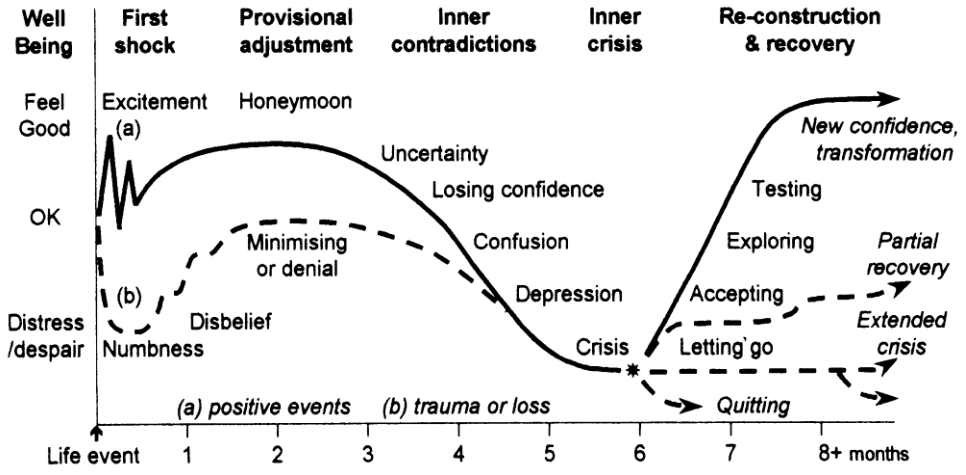

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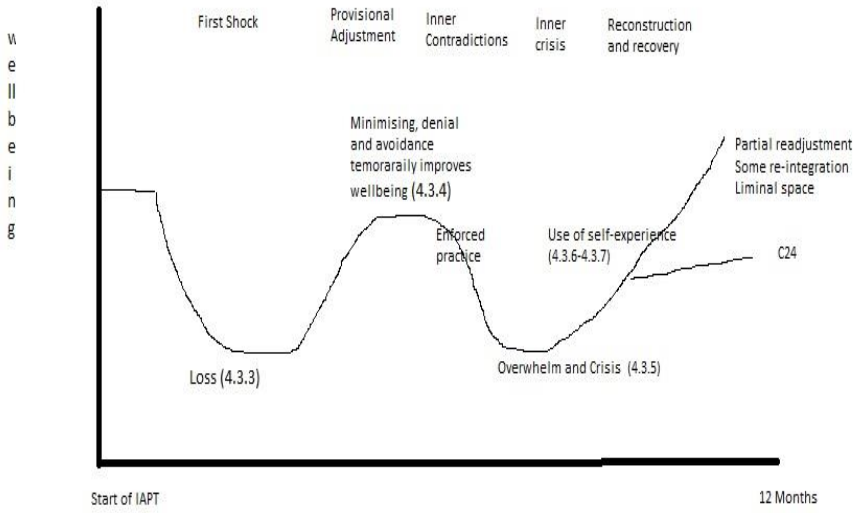
Figure 4.6: An adapted model of counsellors' transition to CBT, using data from this research



The transition model presented above describes various stages of loss and adjustment. The stages (described at the top of the model) remain the same as the original, however, the experiences and responses of the transitioners (recorded on the transition line) show variation from the original. The experience of the transitioners forms the basis for the revised model.

The following section describes how the counsellors experienced the transition process, describing similarities and differences with this model, and proposing some minor variations to it. The first part of the experience is to contextualise the initial experience.

4.3.3: Loss of role, identity, purpose and autonomy – shock

It is of relevance that the advent of the evidence based therapies has had a significantly detrimental effect on the use of counselling in the NHS. The client-centeredness of counselling and the emphasis on individual uniqueness has led to a reluctance to standardise practices. The majority of this sample

previously worked in the NHS and the bitterness is palpable within the sample (See comments about applying for IAPT in 2.2).

Identity appears to not only be bound up in practice, but also in personal relationships, and rewards in the role for the counsellor:

> "I'd formed positive, long term relationships … in some of the surgeries I worked in [as a counsellor], and I felt that what I did made a difference." C24/1.15-16

Within this participant, personal esteem was obtained from the relationships with colleagues and gratitude of the clients. This was not experienced initially on the IAPT training.

Not only is there a fear of a loss of role and a familiar way of conducting therapy, but a fear of abandoning colleagues and losing their respect, coming out of a strong identification with both the practices and the people. This example also highlights counsellor perception of CBT as standardising therapy practice, a repeated theme throughout this chapter:

> "My fears were that I'd lose contact with my long-term colleagues and our shared history; and that I was compromising my personal integrity by joining the service. An additional fear was that I'd lose the respect of those psychotherapy colleagues who were, and remain, opposed to the imposition of CBT and the associated side-lining and discrediting of other models". C24/2.4-9

The role of peer friendship and approval (E.g. Branscombe et al. 1999) and investment in the role (Eaton and Lasny 1978) is known to be influential in role identity, and this appears to be having a particularly strong bearing on this group.

There was also a loss at a more personal level, which appears to include perceived loss as a person, a loss of individuality and a right to a personal philosophical stance in therapy. The counsellors' ability to recognise the best intervention from a range of options is tied up in counsellor identity (See 1.1) and the standardisation that was proposed by Layard (2006) is viewed as a personal attack on the

person of the counsellor, as well as the skills and the profession. The familiar way of practicing is invested in deeply by some, making the process of transitioning from more generic psychotherapeutic approaches to CBT more painful. This was widely regarded as an unfair process by the counselling sample:

> "The Layard… and… IAPT proposals suggested to me limitations on my future role as a primary care counsellor. I was proud of a service I was both a part of and had helped develop; I felt threatened by the changes proposed, and perceived the report as devaluing my skills…" C18/2.14-16

This confirms findings by House (2012) that there is a perception within the non-CBT psychotherapeutic community homogenisation down values skills and creates an absence of meaning for client and therapist.

Loss of autonomy and a flexibility to be responsive to the client appears to be the most consistently valued and perceived-to-be grieved over feature in the early stages:

> "It felt that my individuality was denied, thwarted to conform to one dominant model: CBT. It felt that all my previous knowledge and expertise would be considered not only superfluous but also a potential hindrance. In my eyes eclecticism had been replaced by orthodoxy". C38/3. 4-8

The loss, especially of autonomy, was felt by all counsellors in the sample. Concern about empathy was also present for most. The core conditions are empathy, genuineness, and unconditional positive regard (Rogers 1957):

> I had felt a bit disconnected with some comments from staff around what CBT supervision would be like and the downgraded status of the core conditions. C21/4.1-3

Existing filtering processes of "good therapy" for counsellors are bound up in the centrality of the core conditions, and the absence of this initially devalues counsellor skills, but also devalues their expected status as knowledgeable about psychotherapy compared to the rest of the cohort.

The counsellors decide to join IAPT. This may appear like a commitment to change, but the majority of counsellors did not intend to commit to the practice of CBT at this point, hoping to get the badge, but continue practicing counselling. Therefore at this stage, they were not yet acknowledging the loss and in a state of denial:

> "I was embarking on a new episode – building a CBT conservatory on the side of my 'person centred house'. In my mind I was acquiring the fashionable accessory to complement the outfit that suited me" C21/3.27-29

Counsellors hold differing views on joining IAPT. It is of relevance that a number of counsellors feel that they had little choice except to apply for IAPT if they wished to work / continue to work in the NHS or enhance their career prospects. Empirical observations of cognitive dissonance have repeatedly shown that where there is a conflict between a belief or identity (counselling in this instance) and practicing something that conflicts with the identity, the dissonance resolves in favour of the practice (Festinger 1957, Cooper 2007). However, if the practice is perceived as a forced process with a lack of choice involved, the resolution is less predictable and the original (i.e. counselling) identity may be retained (Linder, Cooper and James 1967, Festinger and Carlsmith 1962).

> "I viewed application for the training post as a potential loss of self-agency…" C18/3.8-9
>
> "It was a head not a heart decision to apply" C25/3.33-34

The notion of loss is repeatedly reinforced in early training – because it is not simply "loss of the old" that presents a problem for counsellors. There is also a need for "acceptance of the new" (i.e. CBT), which from a counselling perspective is often seen as being opposed in terms of values and practice

to varying extents. The perceived lack of autonomy in CBT is reinforced through a requirement of standardised practice within CBT models and IAPT treatment protocols such as psychometric measures. Stroebe and Schutt (2005) describe a similar idea related to "acceptance of the new" when they use the term "restoration orientated stressors", citing skill mastery and identity change as examples, which partly defines the concept but does not fully address a concept "identity resistance", described on several occasions in part 3 of this chapter.

A number of factors are known to inhibit successful transitions between groups or professions, as described in Table 4.4 (Worden 2008). Counsellors struggle in all areas, highlighting a particularly difficult transition process. The transition is also slower than average as a result, as work related transitions at a personal level are usually expected to take 6 months (Kerr-Robertson 2014), however counsellors are still not fully adapted at the end of the 12 month course (see part 6 of this chapter).

Counsellors as a result see themselves as vulnerable, experiencing increased work and personal stress, with reduced levels of support, and little sympathy for their positions. They had invested their personal identity and humanness in their previous counselling role, and assumed that this could at least in part be maintained. The counsellors do not therefore just experience a loss of role, but also a loss of identity, autonomy, sense of competence, and in many cases, income. This has a significant bearing on the transition process, with its strong emphasis on loss. The sheer extent of losses appears to lead to an initial response to loss, that of denial.

Table 4.4: Factors exacerbating difficulties in transition for counsellors (Paralleling loss in Worden 2008)

Factor	Comments	Example
Economic insecurity	Other therapies side-lined with poor long term prospects. Existing NHS jobs sometimes under threat.	My work environment had been stable, safe and familiar... it meant that all was changing." C23/2. 27-28, 30.
Inhibited grieving	Where there is no outlet to express the loss, or socially unacceptable to do so, transition is worse (Worden 2008). Counsellors are used to expression of grief, but the model of management is different in CBT.	"... Therapist identity was threatened. Coming to terms with this, and feeling the loss, there was nowhere to contain the fallout of psychological, social, and professional disruption within the organisation or indeed within the training program" C23/3.11-12
Work environment (See also Fenwick 2013)	IAPT is a target driven service with comparatively tight governance criteria. The perceived coldness, which jars with counselling ideology, exacerbates problems with transition.	"My manager was suddenly terse to me without reason. I felt paralysed and wanted to know the reason" C25/4.13-14
Level of support	Perceived as low by counsellors which is a predictor of poor transitions (Williams 2008). Typical sources of support from counselling are not allowed.	"I used my personal therapist and colleagues for support. I was never previously stressed as a therapist as this support always used to be there" C25/13.6-7
Nature of the attachment to counselling	Enmeshed with identity. When transition moves away from a self-concept ideal, adaptations are poorer.	"I was left with questions about integrating a CBT approach into my philosophy of therapy" C18/5.12-13
Multiple losses	More than role - Identity, autonomy, personal values, expertise, competence etc.	E.g. See "Inhibited grieving"
Extent of the fall from incompetence to incompetence	Unanticipated move from unconscious competence to conscious incompetence	"I really didn't consider the impact of being treated as a beginner or that my acquired wisdom and skill could, on occasions, be perceived as woolly, unnecessary, outmoded..." C24/3.9-11
Continuing bonds	Retention of relationships with former peers reinforces former role.	"My fears were that I'd lose contact with my long-term colleagues and our shared history. An additional fear was that I'd lose the respect of those psychotherapy colleagues who were, and remain, opposed to the imposition of CBT". C24/2.4-5, 7-9

4.3.4: Denial / minimising

The concept of denial is a consistent theme across loss and change models (Kubler-Ross 1967, Adams, Hayes, and Hopson 1976, Bridges 2009) as an immediate reaction to the loss. Denial is defined in this context as "minimise the change or trivialise it"(Parker and Lewis 1981:19). From the description it is apparent that the nature of the denial can take a number of forms. There is a passive form of denial which appears to involve simply carrying on as before, minimising the effects IAPT has on their life, as in maintaining a personal therapist. This is a typical pattern in loss of a loved one, and this is present within the counselling sample:

Denial is typically defined in the context of a failure to accept the loss, but it may be more constructive to re-define it as a failure to accept the reality of the present, which would also incorporate a denial of alternatives. CBT is perceived as selling out from a counselling perspective, not just letting go of counselling, but having to actively reject it. This adjustment is especially problematic for counsellors, going beyond "simple" loss:

> "I began to feel like I had sold out – traded in something vital but didn't really like what I had in return". C21/8.26-27

Sitting with their own peers and effectively creating a CBT "out-group" is one such expression, forming a sort of union in a bargaining attempt to maintain aspects of the former counselling role. The continuing maintenance of former bonds delays the transition as mentioned in 4.3.1:

> "I found myself advocating, with other trainees, the rightful existence of other non-CBT therapies that ... have not forged such a close link with science" C38/3.14-15

> "I sat with familiar peers, all of us stripped of our role, status and reputation…" C25/4.26-27

This is consistent with Sherman and Gorkin's (1980) research that suggests that when behaviour conflicts with core values (e.g. being a good and worthwhile person), attitudes will be bolstered where it is possible to do so.

It has been noticed elsewhere that the majority of counsellors attempt to get a few ideas out of CBT, and get the badge, but continue to practice as before. The process of bargaining, attempting to negotiate a resolution without making significant changes, is present in earlier forms of the transition models mentioned, such as Kubler-Ross' loss model. A slightly more adaptive version of this negotiation process is absorbing CBT into a pre-existing framework, but avoiding learning CBT as a single model. The focus is on adapting CBT to fit their counselling perspectives, not changing the self to fit with CBT, e.g.:

> "I was left with questions about integrating a CBT approach into my philosophy of therapy" C18/5, 6-7

More typical in this sample is a more active denial. Counsellors in their learning journal actively make statements promoting their former profession, and have a biased search against finding positive information about IAPT or CBT. They actively compare idealised aspects of their profession with features of IAPT or CBT that do not fit with counselling. Trivialisation is known to be an active method of dissonance reduction (Simon, Greenberg and Brehm 1995):

> I believe a practitioner does not set out to "fix it" for the other person, but to work with the person to help them find the meaning of the experience" C28/7.25-26

> "Many of the competencies were not competencies that I could readily identify, others that I would consider essential, such as therapist congruency, had little emphasis." N18/6.2-3 see also C24/3.3-5

Two counsellors are a little less invested in a denial process (I.e. accepting the reality of the present, and recognising the need to practice CBT to pass the course) as they recognise that IAPT has expanded therapeutic provision more generally, but they still feelsin conflict about this...

> "Another professional part of me held quite contradictory feelings: I hoped that IAPT would improve the national provision of psychological support and have a positive impact on public perceptions of mental health difficulties" C18/2.15-19

The conflict that this counsellor experiences about CBT appears to accelerate the transition process for her due to a less active denial and a greater sense of openness.

The process of denial is something few counsellors admit to openly – probably because it has the potential to damage their sense of self-worth, but it clearly occurs from their behaviours. The researcher makes no judgement about the reasonableness of this response or the relative merits of CBT versus counselling. However, later on in the journals, the students observe that they were not objective about CBT or counselling, and that biased search maintained the denial:

> "I had finally learned the necessity to have doubts and see them as a potential engine for growth" C38/15.20-21

4.3.5: Overwhelm and crisis

The consequences of accepting the reality of their situation is that of high experienced emotion. The majority of the counsellors identify the start of the crisis for them was an awareness of "Conscious incompetence". It has already been noted that quite a lot of anger was experienced already in the process of initial shock and denial. This is consistent with Kubler-Ross's (1969) assertion that anger normally occurs prior to other emotions during loss, projecting the loss externally prior to addressing it for oneself. This is also consistent with a view in counselling that anger is typically a more "superficial" emotion than anxiety or depression (Kubler-Ross 1969). Anger towards IAPT and CBT

generally does persist into the crisis, and continues throughout as counsellor's expectations are challenged at a micro level.

Students have a number of primary and secondary themes which appear to precipitate the crisis. The majority of students mention that this starts with a realisation that they are not going to be able to continue practice counselling and nominally "nod" to CBT. Attached to this is a realisation that their existing therapy skills are insufficient and they move to believing that they are consciously incompetent. Counsellors self-worth was bound up in their counselling skills (see 4.3), however it is not explicit that this fall is related to loss of self-worth. There is less attachment to counselling and denial at this point, and more focus on the task in hand, but the process is experienced as painful:

> "When I arrived on the training course I believed I was 'unconscious competent" stage in terms of a practicing therapist... moving through the stages to conscious incompetence has been painful and de-skilling"C23/13.5-7, 9-10)

The loss and transition literature emphasises that the determinants of the move from denial to acceptance is to accept the reality of the loss, but this appears to be either inaccurate or insufficient. The move does not appear to be due to a deliberately reflective process on their part except for aspects of C28 and C38. It appears that the enforced teaching, role play, supervision, and the requirement to undertake observed CBT practice may be significant. The issue of observed practice highlights incompetence, even in areas that they believe they are skilled in. The consequences of not accepting their lack of skill in CBT become clear – that they will fail the course. They then feel very exposed, experiencing a range of uncomfortable emotions. This student describes that this is the reason that she is forced to engage with CBT:

> "I began to get a feel for what was a good CBT intervention. This shift had its roots in the realisation that unless I got more focused on CBT interventions I would not get the material I needed for the all-important CTS-R recordings". C21/8.20-24

Although less clearly expressed in other journals, the majority of counsellors only engage in CBT when required to, which causes a crisis, but a greater willingness to experiment with CBT. Counsellors are still uncomfortable with engaging with CBT in the early stages:

> "I felt that I was letting my needs for a tape which adequately demonstrated CBT skills overtake the needs of the clients" C21/8/26-29

Cognitive dissonance highlights that when people are invited to practice something they do not believe in, resolution normally occurs in favour of the behaviour, and a re-scripting process related to the belief then takes place (Festinger 1957, see also 2.3). Counsellors are required to maintain CBT interventions which are observed and rated. This does appear to resolve the inaccuracy of the counsellors' views of CBT from ideologically the opposite of counselling to a psychotherapy that has some overlap with counselling, feeling a little safer, and prompting experimentation with CBT. When perceived as the opposite of counselling, counsellors feel justified in not engaging with it. Unfortunately as well as making engagement in CBT safer for the counsellors, it provokes an awareness of conscious incompetence, and drives the crisis.

Secondary themes have been present from the counsellors from the start of the course, and these add an additional emotional burden to the crisis. An example of this is the relentless pace of IAPT:

> "Another challenge I faced was meeting all the organisational demands, that is... accreditation requirements...academic requirements; and to NHS service delivery demands... the sheer amount of theoretical information...whilst trying to deliver CBT to the client safely ...has been physically and mentally exhausting".
> C23/13.17-22

It is clear that a degree of "space" for reflection and personal reflection is something that is valued by counsellors, and strategies for managing this have been discussed in 2.3. Coping strategies to manage burnout are widely recognised as necessary to mental health (see Wilcockson 20011) and

the reflective space as understood by counsellors is not perceived as valid, or at least not available within the IAPT structure.

A further related theme is the role of autonomy and responsiveness to the client. It appears that, in spite of training in particular approaches, counsellors use autonomic practice to mediate against stress, possibly by responding more flexibly and / or avoiding objective practice judgement from others. Closeness of the counselling profession may also have a mediating effect and this is certainly not present in the early stages of IAPT. Loss of identity, awareness of incompetence, coping with the academic demands, persistent reinforcement of the CBT approach, and a lack of ability to protect oneself, along with personal factors and high levels of self-awareness all amplify the effects of the crisis for the counsellors.

The notion of feeling overwhelmed is repeatedly used as a descriptor of the crisis for all students, although some discuss it in more depth than others. A sense of loss of control is also a universal descriptor and a view of themselves as vulnerable may also amplify this effect. Students describe feeling very exposed, e.g.:

> "In the first few months I felt anxious, unsettled, agitated and had poor sleep. I didn't feel like myself and I disliked feeling out of control...Fear personally and in the service was uncontained and I felt lost and ungrounded..." C25/4.24-25, 5.1-2

This is perhaps surprising given their training, previous personal therapy, and investment in being a "wounded healer" (see Wheeler 2007), this appears to be a new experience for them. Other terms used include out of control, lost and ungrounded, (emotionally) painful, exhausted, anxious, and depressed. Students experience this distress whether they were aware of the denial or not:

> "I felt unsupported and entered a period of feeling insignificant, powerless and de-skilled, my anxiety levels spiralled and spilled over into my relationships at home and at work. I became concerned that I could not contain my anxiety during my work with clients and I began to distrust my capacity to accurately reflect on my work, becoming dependent on supervision" C18/5.17-22, see also C25/4.24-25, 25/5.1-4, C24/7.12-15

These examples show a strong link between disempowerment, high levels of emotion, and a loss of control. This is consistent with a complicated grief reaction (E.g. Hogan and Worden 2004). One student even identifies the crisis in the context of the loss cycle:

> January saw the bottom fall out of the course for me – I remember this as a time of sadness and only my inability to give up on anything carried me through. On reflection I now recognise aspects of the loss cycle... My learning journal is full of blame, anger, disillusionment and demotivated stuckness." C21/8.12-14, 15-16

Counsellors describe their emotional reactions in quite vivid detail. The emphasis on paying attention to the emotions appears to amplify the effects. Although they discuss the process of managing them, there is much less emphasis on cognitions compared with mental health nurses:

> "... and I want to get away or just give up. Despair! Fear! Anger! Frustration!" C24/7/12-15,

In 2.3 a number of features were highlighted that determine the extent of the crisis in loss. C24 has the most severe crisis, and C 18, 21, 23, and 25 all struggle significantly. Both C28 and C38 have a higher level of personal awareness, possibly linked with previous successful transitions which are mentioned within their transcripts, and they are both able to recognise and address the crisis before it becomes too severe:

> "I had been attending to my own shift in affect and teaching myself the basic skills of CBT using myself as the subject to improve my skills to teach my clients these same skills. Initially I felt out of place, my thoughts were "This won't work", clients will not like it", It's too structured", I will come across not empathic" and so on. C28/4.22-27, see also C38/4.10-16

Henderson (2010) asserts that counselling is not particularly an "academic" profession, and the practice is much more valued than the theory. There may be a self-selecting and profession selecting

process in counselling and psychotherapy (people with appropriate personal but not academic attributes, Barnett 2007, Mander 2004). The counsellors that experienced the most severe crises also struggled academically and with the structured format of practice, and this was a source of frustration for them.

There is some variation in experience of the crisis, which is experienced at its most extreme by counsellor C24. The next section describes this variation and the extent of fit with the current model.

Outliers

C24 describes an overwhelming sense of crisis, which also affects her ability to cope. She is probably the most invested in the role of counsellor, and she acknowledges that her previous role had significant affects in meeting her relationship needs:

> "Moreover it served to highlight the important role my [counselling] work has in my sense of myself, in the meaning it brings to my life – I need to feel useful and of value, I want to feel competent and as if I made a difference. I had many moments of crisis – is the meaning I get from my work a substitute for other meaningful (non-professional) relationships: am I too dependent upon my clients for my sense of fulfilment? C24/5.21-25.

This is consistent with Aronson and Carlsmith's (1962) research which concluded that dissonant behaviour / attitudes do not resolve in favour of the behaviour (CBT practice) when there is a lack of confidence in their ability to carry out the behaviour. She is also politically motivated in not becoming part of the "status quo", "rebellious self" is identified as inhibiting transitions by Kerr-Robertson (2014):

> "I've joined the new model army... of apologists and pacifiers" (C24/13).

Due to the stress of learning CBT properly, she decides to disinvest in IAPT:

> "I realised I could not effectively function with this level of distress… I really want to change the way I'm responding to / dealing with my experience of the IAPT training and work. It's exhausting and non-productive to do it as I have been doing – too much anxiety. I need to feel grounded, calmer, more confident… to play the game? Deliver what I need to in the minimum time and with minimum pain…so I can qualify and decide upon my next direction. I need to shrink the IAPT part…so it leaves me more energy" C24/6.24-5, 7.5-16

The feature that links both academic difficulties and investment in a freedom to practice responsively is that of learning styles. C24 describes a difficulty to following structure and holding dual attention (3.15-30), a difficulty seeing things in "boxes" but can see them as a whole (14.25-15.3), a preference for process over routines (11.6-8), and difficulty coping with the IT demands (7.29-30). This is suggestive of a non-linear or wholist, (Riding 2000) processing style such as that described which could suit counselling but would require more significant adaptations within CBT (Structure / protocols for practice, writing in therapy, need for dual awareness, planning, and scrutiny according to an objective structure). This is likely to also be true of C21 who reports having similar difficulties, struggling with conventional education at school, and having dyslexia (which is conceptualised as a wholist processing style by Davis and Braun 2010), C25 also describes some features in common with this.

> "When I had come across linear thinkers as clients in the past, I have could follow them in their individual experience of the world using empathy rather than logic" C21/7/7

Although not all counsellors experience these difficulties, this sample contains a disproportionate number of people adopting this processing style, this fits with both an investment in process issues and autonomy, and in spite of being a small sample, still warrants further investigation.

There is a degree of adjustment from C24, with some recognition that CBT does not fit her stereotype, but this adjustment is limited and at a theoretical level only and from within a counselling perspective...

> "...as we've moved through the course and I've become a little more knowledgeable, I've become increasingly aware that CBT is increasingly recognising the gaps that it needs to address – for example in respect of the therapeutic relationship, early life experience, transference, etc." C24/12.22-25

C24 therefore fails to fully adjust, and although she completes the course, she is unable to reconcile long-term working in CBT with her values. This appears consistent with the "extended crisis" concept in Figure 4.4

4.3.6: Forms of resolution (1) Didactic learning, Consideration of theories and ideas, and Social learning

For the remainder of the sample, exposure to CBT appears to generate a process of testing of CBT, seeing if it is possible to reconcile it with existing beliefs, or formulate a way of understanding it that is consistent with their values. This occurs at global and specific levels. This differs from the transition model described as exploring and testing do not follow acceptance of the need to change and adapt. Unlike most losses, counsellors are not obliged to accept CBT (even though there are strong incentives for doing so), and therefore the acceptance stage of this model is perhaps more accurately described as a "willingness to engage with CBT" stage. In 2.3 it was noted that cognitive dissonance predicts that when practice and values are inconsistent, the dissonance resolves in favour of the practice, subject to a number of caveats, one of which is that the behaviour is not perceived as forced.

This stage involves a process of experimentation with CBT, trying out the skills and observing their effectiveness and their fit with their current beliefs. There is also a process of comparing CBT and

counselling concepts present. Implicit similarities between CBT and counselling are recognised at this stage E.g.

> "I can see now that there are some implicit similarities between CBT and my previous way of working" C25/7/20-21

A summary of the comparison between the skills and the ideas explored by the counsellors is summarised in Table 4.5

Table 4.5: Counsellors experimentation with CBT

	Ref	Resolution
Testing of schemas	C23/4	1
CBT is synthesis – no pure therapy	C23/4	3
Trying conceptualisations	C23/8	1
Changing understanding of relationships in CBT through experience	C23/8-9	1
Agenda setting	C23/10-11	1
Collaborative style of questioning	C23/11	1
Prompt sheets to structure session	C23/11?	1
CBT has a fixed framework, agenda setting, cognitive focus (T)	C18/4	2
Relationships in CBT	C18/4	1
Synthesis of information	C18/5	1
CBT "intrusive"(T)	C18/5	2
Therapist congruency not mentioned (T)	C18/6	2
Personal experimentation with CBT	C18/7-8	1
Experimentation with new techniques	C18/9	1
Therapeutic relationship	C18/11	1
Assessment and SMART goals through experience	C18/12	2/3
Guided discovery	C18/14	1
Therapeutic meaning making	C18/16	1
Model helps collaboration	C18/17	3 / 4
Active stance effective	C18/17	1
Therapeutic alliance	C28/2	1
Structure	C28/4	3 / 4
Conceptualisations	C28/4	1
Practicing agenda setting	C28/6	1
Structuring a session	C28/6	1
Balanced autonomy	C28/7	1
Feedback strengthens therapeutic alliance	C28/7	1/3
Guided discovery	C28/9	1
Formulating own experience	C21/12	1
Told to focus more on nuts and bolts, less on relationship	C21/13	2
Therapeutic relationship	C21/14	3
Behavioural experiment	C21/10	Ambiguous
Eclecticism versus orthodoxy (T)	C38/2-3	2
Exploration of own "hidden agendas"	C38/4	1
Exploration of own beliefs about CBT	C38/5	1
Search for autonomous way of practicing CBT	C38/5	4

Legend: 1 Resolution in favour of CBT
2 Resolution in favour of counselling
3 CBT Re-scripted as counselling
4 Synthesis of CBT and counselling
T Theoretical (non-practical) experimentation

There are broadly four conditions that occur as a result of this experimentation; that resolution occurs in favour of the counselling, that resolution occurs in favour of CBT, that the CBT intervention is re-scripted as a counselling intervention and there is not perceived to be any difference, and that there is a synthesis between counselling and CBT. The relationship between counselling and CBT is that of an overlapping relationship with many independent features on both sides. This would presumably need to harmonise in order to reduce emotional tension (Nicholson 1984).

There are a number of ways in which resolution occurs such as through didactic learning, consideration of ideas / theories, and social learning, which will now be explored in greater detail.

Didactic learning is a considerable part of the training, whether through lecturer, manager, or supervisor, although there tends to be comparatively little said about this within the journals. The impact of didactic learning is relatively benign or actively resisted at the denial stage, but even at the exploration stage, there is nothing to prevent the students again distorting concepts and the outcome becomes more ambiguous, although learning does occur from this, more for some than others:

> "The aspects of the training I enjoyed were the structure and learning new theories, shared by the trainers with passion and enthusiasm" C28/4/11-12

The level of knowledge required is described in several journals as problematic and intimidating for counsellors. The one clear example of didactic learning at the exploration stage prompts resistance from the student; however there may be examples of learning which do not conflict with the student's values at this stage. It is relatively easy to reject or distort concepts not based on experience, so the impact of didactic learning is that of a "cut and paste" approach, taking what fits with what one is prepared to accept, and rejecting the rest:

> "I'm reading Marsha Linehan's CBT for Borderline Personality Disorder – very good. I've got enough nous to disagree with some of it, but I like her style, her

> scholarliness and her compassion. It makes me realise I don't read the others because they don't interest me". C24/11.11-14

Counsellors compare ideas and theories between counselling and CBT as part of the transition process. In the journals, 20 examples of comparing CBT and counselling ideas were present which had a relatively clear resolution for the counsellor. Only one of these comparisons resolved in favour of CBT, and four had some form of integration, absorbing aspects of CBT but retaining some aspects of counselling which are "not CBT". Thirteen, or 65%, resolved the comparison in favour of counselling, and a further two re-formed CBT as a form of counselling (e.g. "CBT uses the therapeutic relationship, so does counselling, they must be the same, I can carry on as I am…"). When the counsellor is able to compare counselling concept with CBT concept, there is no need for the concepts to be accurately represented. Therefore, concepts tend to be interpreted through the lens of the counsellor's current understanding, either by emphasising positive aspects of counselling or by emphasising negative aspects of CBT. CBT does not practice positive psychology, but this therapist draws parallels with the quote below and CBT / IAPT:

> "I bought Barbara Ehrenreich's smile or die last Friday and read it on Saturday. It spoke to me, challenging the drive to be positive about everything, and get blamed if not..."C24/5.9-11

There appears to be a relatively wide scanning by the counsellors of CBT ideas, and absorption of new information, but only when consistent with core counselling values. This allows the counsellor to re-construct an identity which is self-congruent, such as noting the relationship as collaborative (C23/25-26), focusing on trans-diagnostic explanations (C18/13/5-7) and working at a deeper level of belief and process (C24/11/11-19).

Sometimes social learning and modelling occurs as a way of comparing / testing CBT out in the context of their counselling experience. This happens in a number of ways, including teacher

modelling, supervisor modelling, and videos. A number of counsellors discussed watching a video in class of Christine Padesky, an archetypal American CBT therapist during teaching sessions, and described mixed results. To set a context, Padesky is quite charismatic in her delivery of CBT, and her approach would not necessarily work with British clients. Although a skilled therapist and this is recognised by most counsellors, there is an opportunity for counsellor views of CBT as over-structured and un-empathic to be reinforced.

> "I liked her attention to client communication and her ability to synthesise; however I experienced her as intrusive C18/5.4-5

If the social learning is made directly relevant to the counsellors, with additional opportunities to ask questions / consolidate the learning, the learning is more likely to be absorbed, and there are several examples of this occurring in clinical supervision, e.g.:

> "Supervision helped strengthen my identity as a CBT therapist. Together with self-reflection it helped me integrate self as a therapist and self as a person during my training. It was a safe place where I had the opportunity to bring together what I had learned about CBT theory and therapeutic strategies with the complex reality of clients I was seeing…" C28/12.26-30, see also C38/6.16-18

The above extracts suggest that there is something about the process of experience and practice that reinforces learning and identification with the learning far beyond that of social learning. The concept of cognitive dissonance as already discussed appears consistent, but the fact that, in experiential learning, the therapist is allowed to apply the technique autonomously (e.g. using own words not Padesky's) according to their own style, and most importantly to the needs of the client are all important.

A further factor that emerged from the data was self-reflection in the resolution of transitional conflict. This was shown in forty five examples of learning and thus is treated as a separate theme below.

4.3.7: Learning through self-experience and self-reflection

Although all forms of resolution had some kind of effect, the form with the strongest impact was an adaptation of self-practice, where the counsellor experiences the problem "as if" a client. This involves experimentation of CBT skills with themselves, and also experimentation of CBT with their clients. Thirty six of these examples, or 80% resolved in the support of, or adoption of, the CBT practice, corroborating cognitive dissonance research (Festinger 1957). This occurs reasonably successfully even where previous levels of resistance have been high:

> "The fact that I was able to formulate my own experience, boosted my experience in CBT significantly..." C21/12.19-20
>
> "This unexpectedly positive experience energised me to learn more…" C25/7.17-19

The more structured form of reflection is adopted universally by the counsellors, involving CBT processes such as guided discovery:

> "I have learned the power of having doubts, being curious, and to always explore new potential views" C38/17.12-14, See also C21/15, etc.

From the examples, some important themes emerge. Where the counsellor is able to fully experience the therapeutic technique on themselves, there is a resolution in favour of CBT, with occasional synthesis of CBT with counselling. The notion of a "parallel process" is seemingly helpful. A parallel process occurs when the therapist has similar experiences / difficulties to the client, often

affecting delivery of therapy, and the therapist adopts the role of client in clinical supervision as a result (e.g. Morrissey and Tribe 2001):

> "I feel lost and ungrounded – and the parallels with the experience of my clients are obvious" C25/5.4
>
> "At this point I really had to stand back from my clients too and be very mindful of my own and client's schemas, and be able to make a distinction between the two so it did not impact negatively in therapy". C23/8.25-28, see also C38/12.24-25

The way in which counsellors approach the experimentation with CBT is worthy of further explanation. The most practical way of doing this would be simply to identify the problem, and then use the most appropriate skill or technique on themselves. Although this does occur, the most common approach appears to be to place themselves in the role of client (or observe a parallel process between themselves and their clients). The counsellors have already experienced the role of client in the initial crisis experience, see page 200.

> "This training process itself has reflected a developmental process for me in that I have revisited some of my deepest doubts and core schemas around being "I am inadequate", "I am not good enough", "I am incompetent", and "I am a failure "and maladaptive assumptions and behaviours to cover over these…. It caused personal turmoil and disruption to my core being / identity which has had to be managed..."C23/4.17-23
>
> "Being in touch with my own vulnerability has helped…" C25/5.9-10

Counsellors then observe and experience the problem, and try out the skills on themselves, making appropriate refinements to the therapy to fit with their own experience. There is a strong emphasis on insight into the cognitive distortion, rather than emphasising a direct challenge to that distortion:

> "At times I was able to identify my own negative thoughts, when in particular I was comparing myself to experienced CBT therapist and undermining my confidence". C23/4.26-27

Use of former skills and concepts, including self-in-therapy, adopting the client perspective, and use of parallel process, are important for counsellors in bridging old and new knowledge. A subtle distinction is that the counsellor emphasis is on the client experience of the therapy, rather than the therapy itself.

There are a few exceptions to this "resolution through experience"; resolution does not occur when the therapist does not fully commit to experiencing, or doesn't understand the purpose of the experimentation:

> "When the concept of self-practice was introduced I must admit I was rather sceptic and the first attempts with activity scheduling and mood monitoring were short lived. I didn't feel I required them and as a result I did not feel motivated to practice them". C38/8/20-24

Resolution also does not occur when they do not have confidence in their ability to undertake the task (See Aronson and Carlsmith, 1962, 4.4, also C24/6.2). Some examples of experimental with dissonant themes addressed by counsellors are described below:

CBT may be described as a very broad range of approaches (Westbrook et al 2011), but it does normally include a degree of structure in delivery, fixed models, protocols for treatment for specific diagnoses, and a number of techniques that involve rigid structure compared to other therapies, such as agenda setting, homework setting, exposure, etc. (Townend 2005). The consequence of practicing the majority of skills appears to lead to an understanding of the purpose / function of the structure, respecting the structure when it is appropriate to do so, but adopting a flexible approach that is client centred for the most part.

> 'age'nda setting was difficult at first, but if I avoid jargon and bring myself into it, it can be done with a human touch to the benefit of the client" C25/12.20-21

Note that in this example, the counsellor alters the process "human touch" to compensate for the once engagement with CBT has occurred and initial reflection has taken place, a pragmatic approach is taken to the implementation of CBT in practice, but structure and distance as an ideology is generally not identified with:

> "I think I may always struggle with the need for distance and the business-like approach of CBT". C25/12.18-20

CBT remains the principal framework for therapeutic engagement provided that the counsellors are able to place a strong focus on the centrality of the client (rather than the therapy or any particular technique):

> "I can now see myself as a clinician who can focus on the centrality of the clients and their needs, and not on the type of therapy I deliver".C38/17.4-6

Many counsellors start from the perspective that because CBT is structured, it must also be un-empathic, and also start from the perspective that the only way to contain emotion is through shared experience of it in the therapeutic relationship. Views on this are revised, such as the fact that structure can be delivered in an empathic way:

> "Although cognitive therapy is quite directive, proper respect for collaboration prevents any tendency towards authoritarian practice" C28/13.24-25

Another view that is revised is that the only way to contain the client is through the therapeutic relationship. Counsellors find that structure can have similar effects as those previously provided by the therapeutic relationship:

> "I've been surprised that the structure of the formulation seems to have helped contain the client..." C25/7/23

> "I have learnt that asking for feedback...helps to strengthen the therapeutic alliance" C28/7/13

4.3.8: Creation of "The counsellor/CBT therapist"

At the end of this process, and for the majority of the sample, the counsellors are broadly practicing CBT however some themes remain in ongoing conflict. The counsellor and CBT therapist could use both professional identities in practice, but do not belong to either identity which could cause ongoing conflict also referred to in the literature as liminal space (Croft, Corrie and Locket, 2015b).

The exception to this is C24, who retained her identity as an integrative therapist, the reasons for which are explored in 4.3.3.

> "... and I don't feel I've lost my identity as an integrative practitioner" C24/15.11-12

For the remainder, there is a noticeable shift in both attitudes and practice, and some counsellors are able to reflect on this.

> "CBT permeates my thinking now, I have become aware of differences in language and how I structure my thinking when I meet former colleagues…" C25/12.15-18

One factor in accepting a CBT identity appears to be when they feel that their individuality and personal style is safe, a freedom to be responsive to client need. This safety increases as counsellor perspectives change with greater experience of CBT, and also lecturer and supervisor's attitudes towards them soften as a result:

> "It felt that my individuality was safe that, still within CBT, I could cut my own idiosyncratical way of delivering therapy" C38/5.27-28

In practice there is a degree of synthesis, merging old counselling ideas and practice with new CBT ideas and practice. An example of this is the right to practice autonomously and be responsive to the client's needs. Although specific interventions are expected to be delivered within client diagnoses in order to adhere to the evidence base, (e.g. Butler, Chapman, Forman, et el. 2006) the counsellors do adhere to these interventions, but remain flexible, and also more client (rather than therapy) centred in the way that they are delivered than would normally be typical in CBT (See 4.2.4)

CBT, as previously stated represents a broad church of views in therapeutic approach, and it would certainly be reasonable to suggest from this sample that the counsellors represent a humanist "wing" of thinking within the CBT community. It is very difficult to be clear about whether there are any aspects of counselling practice retained that are clearly "not CBT" – especially as the boundaries of CBT are poorly defined so this would involve a value judgement in defining the limits of CBT. Being on the humanist "wing", not having to become an archetypal therapist may allow for greater retention of former counselling skills, and "saving face" from the earlier perceived humiliation of unconscious incompetence, etc. There seems to be a continued willingness to look beyond CBT when it is helpful to the clients to do so, e.g.

> "I struggle to see CBT as a panacea" C25/6.11-12

> "This year has allowed me to discover a great deal about CBT but also about myself: both have strengths and limitations" C38/17.6-8

There is clearly a reasonably high level of identification with CBT, by the end of training; it is certainly viewed as much less in conflict with counselling than previously. There is not much evidence of shedding of counselling knowledge, but structuring rambling clients and referring on where likelihood of a positive outcome is low are two such examples:

> "In my reflections, I realised that as a counsellor I offered my clients therapy when my assessment may not have indicated a successful outcome". C23/12.10-11

> "I reflected on other situations...In which I evidently colluded with my clients covert agendas (e.g. not exploring certain areas, trading empathy for over-involved sympathy, endless listening to clients offloading).It was evident how collusions could only lead to an unsuccessful therapy" .C38/16.4, 5-8

The identification, and, where present, shedding of former beliefs and practices almost entirely occurs through experience and very rarely through conceptual comparison. Self-practice of CBT is adopted as a general rule and this becomes a coping strategy for counsellors, this helps lessen the dependence on autonomic practice, peer support, and personal therapy, enabling the counsellor to take more responsibility for their wellbeing. This reinforces identification and practice of CBT.

> "...I had finally learned the necessity to have doubts and see them as a potential engine for growth. I learned to look beyond the content of my sessions and look deeper into meanings that could be explained by an underlying process." C38/15.20-23

If the counsellors are clearly not archetypal practitioners, so it is worth clarifying which aspects of CBT are not adopted. The most obvious aspects of this from the journals concern rigidity and structure. Counsellors repeatedly express a dislike for more "scientific" aspects of CBT, form filling, measures, adhering to rigid protocols, etc., and there is some evidence these are only weakly adopted, or only adhered to because it is a service requirement;

> I've really struggled with the routine application of diagnostic categories, formulations, and treatment plans that characterise CBT. Many of the texts remind me of the Haynes car manual series and I've found them boring, so although I've bought lots of them, I haven't actually read them until I've had to…." C24/11.6

4.3.9: Growth and ongoing development

A number of counsellors report growth from the experience and some authors on this, such as Hopson (1981) are able to acknowledge that this often occurs in the process of transition. It seems that, according to such theorists (e.g. Ashforth 2000), the more investment placed in learning a role, the greater the identification with it. We noted earlier that the process of learning in counselling is "hard fought", having to overcome their own personal issues in the process. This may reflect a strong identification with counselling. A similar process occurred within the training under research, and the experiential aspect certainly was influential in enabling the growth process. All counsellors have a healthy respect for the learning process:

> "As a clinician I feel I have grown considerably since [start of the course] as I have been able to learn from my success and the problems I encountered. Every opportunity has enabled me to learn more and to apply new ideas and strategies to myself and to my clinical practice" C38/17.9-12

Counsellors widely recognise that they are not the "finished product" (explored in Phase 3) and are continuing to develop in knowledge and skills of CBT at the end of the course, however the course marks a plateau in learning where consolidation and reflection can take place:

> "I am now arriving at a clearing with a great sense of relief, and assessing the process through reflection to make more sense of it". C23/14.3-4

> "One of my supervisors told me that someone in the teaching team had said that they saw me at the beginning of the course I think I was indeed keeping safe. In part the bunker was about damage limitation but I caught the blast anyway and now I'm emerging – and it's good to be out!" C21/16.1-4

One analogy that may be relevant is that it is similar to learning to play each hand of the piano – the CBT hand and the counselling hand, but it takes time to play them proficiently in harmony. One has to stop playing one hand in order to learn the other, and only when both hands have been learned independently, can learning take place:

> "It became clear from comments in class that people were not able to do the relationship and mechanics all at once. Perhaps it's a little like playing the piano – each hand is practiced separately and then together. I'm struggling to get both going together" C21/12.12-13

There is a recognition by counsellors that, in spite of a respect for CBT, that it will still take a considerable period of time to become naturally proficient. This contrasts with the initial view of CBT as simple and mechanistic:

> "The next stage is the consolidation of learning by clinically practicing over time and so being able to move to the conscious competence proper" C23/13.13-15
>
> How can one grasp CBT in its fullness in a year? C21/15.6-7

The issue of conscious competence in CBT is clearly present, but unconscious competence in counselling brings with it on-going challenges. There is a strong pull back to the familiar, both in terms of habit and avoidance of discomfort for example:

> "The temptation will be to get lazy and relax into an impoverished integration once the course has finished (which does justice to no-one)" C21/15/8-10

4.3.10: Discussion

The objective of this aspect of phase 2 of the research was to develop a theoretical understanding of how counsellors learn and transition to CBT**.** Analysis of the counsellors learning journals revealed that the process of learning and transition for the counsellors is complex, following an adapted version of the theory of loss (Kubler-Ross 1969). Almost all factors known to complicate transitions and / or grieving are present in this sample and a complex denial process that includes an active resistance and sabotage of CBT, not just loss of counselling. The attachment to the principles and practice (but not necessarily the profession) is felt strongly and existing skills including parallel

process and experiencing as a client, are important concepts that eventually enable the transition process.

The move out of denial does not occur spontaneously and only occurs when counsellors are forced to practice CBT, submitting taped sessions to their supervisors for assessment. Engagement in CBT kick starts a state of high emotion, leading to a crisis. This is less severe if there is some awareness and preparation during the denial phase (C28 and C38). The crisis is experienced deeply from an emotional perspective, but practice of CBT also creates dissonance, revising the counsellors' view of CBT to a position where it overlaps with counselling. This stimulates a period of engaging with CBT. Counsellors address personal issues using CBT, but there is much more emphasis on the client (as opposed to the therapy) and emotion than is typical elsewhere in CBT. Self-awareness during this process is quite high.

The journals reveal that the most successful adaptations are through experiential learning, trying out skills on themselves and with clients. Social learning is also influential, especially in supervision. Didactic learning and comparison of ideas are less successful in encouraging adaptation or synthesis. The product of counsellor-CBT therapist is not universally consistent amongst the sample, but represents a "fringe" or "wing" of CBT which is more process driven, client-centred and emotion centred than the prototype. There is some non-adoption of more protocol driven aspects of CBT. A realisation that they were able to practice autonomously within a framework is a significant factor in identification with CBT, and still retain some counselling principles, is highly influential in the process of learning for this group.

4.4: Results - KSA

4.4.1: Introduction

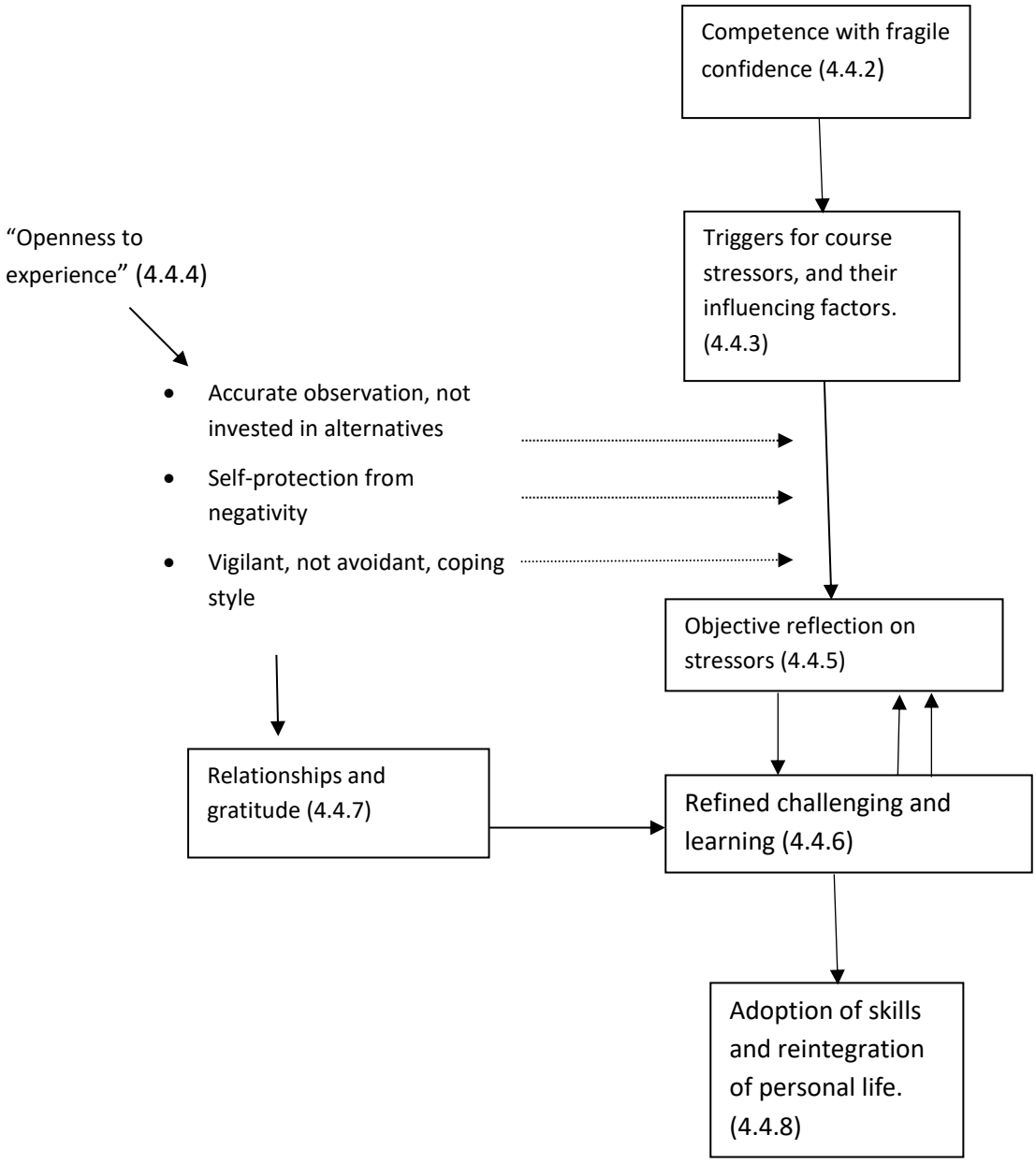
In order to be accredited by the BABCP, and IAPT, there is set criteria for therapists with appropriate training and core skills to become therapists in the absence of a core profession. These 14 criteria are described in greater detail in Table 2.2. The absence of a core profession serves as a useful "baseline" group to observe which factors are reflective of the IAPT training (universal factors), but also to observe how students learn in the absence of prior professional identity and practice.

All of the participants within this group describe having some CBT experience. Three students describe themselves as graduate mental health workers, and another two describe working in forensic units, apparently using reasonably high levels of skills, albeit under fairly close supervision, with a complex client group. A further member of the group has considerable CBT experience, but does not specify the context. A number of the group are educated to masters' level, higher than the majority of the counselling and nursing groups. Although there is experience and education in relevant areas within this group, they have not been merged in the form of a core profession.

Students from the KSA group remain an influential grouping, but within this, Psychological Wellbeing Practitioners (PWP's) have become a further grouping. PWP's have received one year's training in delivering brief, simplified CBT to low intensity clients. There is insufficient training in core skills for PWP's to qualify as a core profession, therefore they are required to qualify via the KSA route. At the time of the research, there was insufficient numbers to make up a PWP group, and consent was low within this group. The equivalence in knowledge skills and attitudes while lacking core professional skills means that a decision was made to include PWP's. There is an acknowledgement that the KSA group is more diverse in terms of how they obtained the KSA criteria, however there is an absence of professionalization which may impact on transition. A model of transition (Figure 4.7) has been

developed from the learning journals from the current research (outlined by themes) and discussed in further detail.

Figure 4.7: KSA Model of learning CBT



4.4.2: Competence with fragile confidence

Members of the KSA group are less prone to talking about their previous experience, as there appears to be less conflict between what is being learned and previous experience, and therefore less reason to be aware of it. They do, however experience some processes unique to them, and clarify some issues that are present in all groups and seemingly universally experienced during training.

In spite of a positive profile, there is a general fragility in the KSA group's sense of confidence:

> "One of the areas I felt most anxious about when I started was about my lack of knowledge and understanding between different services within the voluntary sector, primary, and secondary care" K37/14.4-10
>
> "I felt that everyone was more experienced in mental health than me" K74/2.16-17

There is the sense of other professional groupings having greater knowledge and skill, although there is a genuine lower level of knowledge about some cultural aspects of the mental health system (diagnosis, where to refer, etc.) with some KSA students. This aspect of the knowledge is relatively minor, and in terms of clinical work, all of the students reported feeling skilled in their previous role, and this sense of competence is generally brought into the role, e.g.:

> [Previously] "I was highly competent in my work, [and] had a thorough knowledge of systems and procedures" K36/3, 6-7

However, in spite of evidence of competence and a general belief in their skills at this level, some members of the KSA group felt that their views were not respected because they were not professionalised. For some, this was a motivating factor in applying for IAPT. Many worked hard to overcome this handicap and achieved respect as a person rather than as a professional expert:

> "The company were unsupportive of my chartership and I soon became unhappy". K37/1/24-25
>
> "Working as a graduate mental health worker... My professional opinions were rarely taken account of..." K35/12.24, 25

In spite of this overall general sense of inferiority, there is quite a significant hopefulness and confidence in overcoming adversity, consistent throughout the sample and a seemingly important characteristic of this group:

> "I felt optimistic and motivated to learn and was hopeful that the trust and university would provide support..." K37/2.25-27

This is not something consistently present within nursing or counselling samples. It was noted in phase 1 of the research that this group had relatively high levels of pre-existing CBT skill and reflective abilities, and hypothesised that a lack of professionalism prevents contamination of expectations. The same factor may be influencing this underlying positivity.

In summary, the KSA group are categorised by exclusion, not fitting into other groups categorised by training and professional identity. This group have equivalent levels of academic ability and experience as the other professionalised groups, but have not integrated these into professional training. Initially they do have some concerns about inferiority to professionalised groups, but appear relatively uncontaminated in their expectations and relatively optimistic about the IAPT training.

4.4.3: Triggers for course stressors, and their influencing factors

The KSA group report experiencing the same practical difficulties as counselling and nursing, suggesting that the external environment is not a significant differentiating factor. Neither is an initial emotional response to problems such as fear, overwhelm, etc., suggesting that the emotional experience of this group is not fundamentally different, e.g.:

> "When I was told I was going to be assessed and have to carry out tapes of my sessions I was initially horrified." K26/8.18-21

The students also carry their own emotional burdens from the past into the training, and this generates emotional responses during training. However, these beliefs are held at the level of the individual and there is no suggestion within the sample that they are held at a group level, as expressed by mental health nurses and counsellors:

> "I am undoubtedly a people pleaser, I like to be liked..." K36/11.20
>
> "I have found throughout this course that I have had to address some of my perfectionist tendencies which have probably been in place for many years." K67/7.8-9

Two factors appear to be influencing the perception of the triggers. One of these is the activation of schemas, defined in the narrow psychotherapeutic sense e.g.

> "Self-defeating life patterns of perception, emotion, and physical sensation. " (Young et al. 2003:6).

All students report becoming aware of a perfectionist, or unrelenting standards schema, and a number also reported a self-sacrifice, or people pleasing schema. The dominant concept of perfectionism, or unrelenting standards, is described by Young et al. (2003:17) as: "The underlying belief that one must strive to meet very high internalized standards of behaviour and performance, usually to avoid criticism. Typically results in feelings of pressure or difficulty slowing down"

The concept of schemata is taught on the course and the KSA group readily adopt this idea. An example of perfectionism is:

> "I gained more insight into how my schemata manifested in therapeutic sessions and the interplay of these with clients' schemas (Simos 2009). I have been aware of my perfectionist tendencies" K40/9.11-13; see also K67/7.9-10; K26.10.18-22; K35/4.1-7; K36/4.1-10, 15-19; K37/11.4-7.

The notion of having unrelenting standards or perfectionism i.e. "I'm not good enough" schema is a comparative one, rather than an absolute one (e.g. "I'm no good") (Young and Kloso 1994) and this is significant in the context of how the students react to it, as will be noted later in 4.4.5.

4.4.4: Openness to experience

Another feature of this group compared with professionalised groups is an ability to actively discriminate between what information they absorb and what they ignore right from the start of the course. Among the nursing and counselling core professionals the process is much more passive, absorbing more anxiety and in some cases coping by amplifying it. This KSA group appear better able to protect themselves from negative information and take a more objective, or sometimes self-nurturing perspective. There is also an awareness of broader issues at times. This is a concept understood within CBT (E.g. Wells 2008) and is likely to reduce negative interpretations of any triggers:

> "There was a lot of complaining around trust issues and some individuals could be rather negative" K26/2.13-14,
>
> "...furthermore this was compounded at work [i.e. IAPT] by some colleagues who were excessively vocal about their own anxieties" K36/3.11-13

This ability to self-protect from negativity reflects a more objective perspective on stress triggers. Objective attentional regulation is known not only to reduce the emotional effects

of a trigger, but also to reduce the resulting dysfunctional coping strategies, such as worry or avoidance (Wells 2011). Research in CBT identifies two distinct attentional biases; vigilant and avoidant (e.g. Bogels and Mansell 2004). Those with vigilant coping processes showed faster and greater treatment gains than the group with a more avoidant coping style (Price, Tone, and Anderson 2011). It was hypothesised that active coping allows the negative thought (e.g. "I can't cope") to be challenged, whereas avoidance prevents disconfirmation. Over-engagement is a typical coping strategy for those individuals with an unrelenting standards schema, in an attempt to meet those standards.

The stress related triggers describe, for the most part, a universal experience which includes a lack of perceived support from managers:

> "...at work I was feeling there was a sudden expectation that because I was on the IAPT course that I had suddenly gained a huge amount of knowledge and experience that I didn't actually have." K67/4.12-14

For the majority, the KSA students believed that the course would be easier and they would be more competent at the start than they were, which appears to be a universal experience across all professions, although this belief is not completely dichotomous within the KSA Group with some students appearing to have a realistic view of themselves in this context. This student typifies the initial over-optimistic stance:

> "I over-estimated my ability to cope with the demands of a new course. I believed I was knowledgeable about CBT and experienced in delivering CBT interventions...I soon realised the gap between guided self-help work and full CBT was wider than I had appreciated, and the path to becoming a competent CBT therapist was longer than I thought. K35/8.7-10, 20-22

Fear of failing tapes (e.g. K74/4.15-16), academic challenges (e.g.K26/3.1-4), managing work-life balance and risk of burnout (e.g. K40/10.18), and, for those in the first intake, issues of setting up

the service (K40/12.6-9) are all present. These factors are attributes by mental health nurses and counsellors as contributing to a difficult transition. The fact that these factors are also present in the KSA group who experience a less problematic transition indicates that it is more likely to be student responses to these circumstances that is more influential, and the lack of pre-conceptions in the KSA group may be assisting the transition process.

This positive attitude, the lack of bias in observation, a lack of avoidant coping, and some pre-existing ability to filter out negative emotions and cognitive flexibility, appears to be broadly indicative of a larger concept, "Openness to experience" which is a validated domain within personality assessment (Big Five). People with this personality factor are more likely to be proactive, and also cope better with diverse experiences (McCrae and Costa Jr. 1987) consistent with this sample. They are also likely to learn more efficiently in all styles of learning (e.g. Kommaraju and Schmek 2011). A high level of cognitive flexibility appears to assist with challenging negative interpretations, as does the lack of biased expectations. This appears to work according to the mechanism described in Rachman's (2009) work suggesting that for internal change to successfully occur there must be recognition of the negative distortion, the emotion, and an available alternative. Negative distortion and emotions are objectively noticed quickly and efficiently, but the positive attitude and lack of biased expectation leads to a quick availability of an alternative perspective in this sample, therefore no biases are present to interfere with cognitive processing, consistent with CBT theory (E.g. Mobini and Grant 2007).

4.4.5: Accurate reflection on stressors

As a general rule, stressors are identified, reflected on, and managed promptly and successfully in accordance with the reflection-in-action model (Schon 1983, Chaddock et al. 2014). In the initial stages, however, there is a theme of over-engagement present throughout the sample. Over-engagement is common in relational schemas, striving to achieve being "good enough" Although

over-engagement may be seen as a dysfunctional strategy, it does not inhibit disconfirmation of schema in the same way that avoidance and rumination, noted in 4.2 and 4.3, does. The over-engagement applies to both client and academic work:

> "Sometimes clients impact on me in a negative way, e.g. people are ambivalent and not motivated to change. With these clients I can put pressure on them and myself... I am aware I do this at times, particularly when clients need to work at a slower pace". K26/10.16-19, 22-23
>
> "I have always planned sessions at home, helping me achieve high standards and to protect myself from perceived failure during clinical work". K35/4.3-5

Much of the time, however, KSA students do cope well with universally experienced stressors during the course of training. Additionally, as a general rule, they identify the problem quickly and without distortion, and deal with it accordingly:

> In the first week: "... I dreaded coming in [to university] the following day. However I did what I always do in those situations and threw myself in wholeheartedly and found at least one common ground with nearly everyone. This helped to shift some of my core belief..." K67/2.25-9, see also K37/9, above, K35/7.24-30, etc.

A lack of previous experience appears to help these students avoid interpreting uncomfortable experiences in a non-objective, biased or negative way. This contradicts commonly held positions on professions adding value in judgement, either due to specialist knowledge, or professional standards (e.g. General Medical Council and Nursing and Midwifery Council 2012). This is probably because there is a lack of investment in alternative perspectives driven in other populations by the core professions. There is also a positive nature and attitude throughout the sample, which allows opportunities to be taken and the negative to be problem solved or not dwelt upon:

> *"Further obstacles within my work environment included lacking effective procedures and problems accessing GP surgeries... however these events*

manifested into useful learning opportunities". K37/3.2-5, see also K26/11.21-22, 40/8.11-14

There are also a number of examples of repeated stressors, where there is discomfort experienced, but not an unnecessary dwelling on the problem, and there is evidence of resilience in coping with the problem. This indicates that, although according to CBT theory the levels of emotion may be lower due to the more balanced attentional processes, difficult emotions are still experienced by the KSA group, suggesting that it is not the extent of the emotion itself that reflects the differences between the groups. Accurate appraisal, resilience and functional coping strategies are, however, largely present from the start in the KSA group, which is not necessarily present elsewhere in the nursing or counselling group. An example of where there is a need for repeated resilience is outlined in the excerpt below:

> "On several occasions one of my supervisors has given guidance that contradicted my conceptualisation of a case prior to presenting it at supervision. This produced a strong reaction in me, and caused me to feel particularly deskilled. I have often left supervision feeling demotivated and considered leaving my course and my job. I have usually been able to process these feelings, remind myself that I am a trainee, and build my confidence again in time for my next clinical work the following week. This has been occurring less frequently recently"...K35/7.25-8.1

4.4.6: Refined challenging and learning

KSA students tend to screen negative information comparatively objectively, and without excessive focus on the negative. Students see themselves as positive in attitude, and generally optimistic, and in some cases, their peers note this too:

> "Colleagues have often commented that whatever is going on at work, I am always positive and keep smiling" K35/13.30-31.

Stressors seen as problematic in other groups are viewed as opportunities in the KSA group, and seen as opportunities for learning.

> "[This year] has been a really useful opportunity to tackle my perfectionist tendencies and to find a more balanced view of my self-worth..." K67/9.20-23, see also K35.7.31-8.4

The positive attitude described in previous categories may additionally assist with noticing the positive effects of change as a result of challenging negative thoughts. There may be a multiplier effect of positive experience, and there may be more generalisation of learning, and openness to more learning opportunities. For example, this student uses her positive experiences to assist others' learning, and teaching reinforces her own learning. There is a conceptualising of adversity as opportunity and growth.

> "Having to balance being a mum [personal information withheld], working and studying with no family support nearby has been difficult at times. However, I am now more resourceful." K26/11.21-22,
>
> "As I grew in confidence I was able to help some of my colleagues who did not have much experience in CBT… Unexpectedly helping others had quite an impact on me as it made me more confident in what I knew and did as a therapist. Working with colleagues enabled me to learn from them…and helped me consolidate my CBT skills." K40.7.12-14, 15-17, 17-18

The changing of thoughts and behaviours occurs promptly, but it also occurs efficiently and in a refined way - for an extended example see K36/5, 16-29. Both knowledge and experience based challenges are employed to existing knowledge and a wide range of different changes are made which have a strong positive effect. The ability to access the most effective strategy from their new and existing declarative knowledge functions well and also helps to implement the challenge in practice – previous experience does not appear to interfere with declarative knowledge in any way. There is an openness and keenness to learn from experience with self-practice and client practice.

4.4.7: Relationships and gratitude

The positive attitude also pervades the students' relationships with teachers and supervisors and, also in this group, other professional colleagues who are influential in the process. The engagement in these relationships may have derived them additional benefits in terms of support and guidance. The gratitude for this in the sample is palpable. There is surprisingly little research on the effect of gratitude on outcomes in CBT or other therapies.

> "One tutor enriched my experience in a remarkable way…" K26/6.13

Although there is an awareness of the support of others in the nursing and counselling groups, the sense of thankfulness for this is much more present within this group. This gratitude is a sort of active positive filtering, which conceptually overlaps with other features of this group in the transition process, such as screening out of negative information in 4.4.4.

4.4.8: Adoption of skills and reintegration of personal life.

After repeated reflection and learning, themes of trying less hard, making themselves vulnerable and self-acceptance are pervasive, and generalisation occurs beyond immediate learning pervading into the clients personal life too:

> "When trying to work through this guilt it also became apparent that I was not only trying to be a perfect therapist, but also a perfect mother, if such a thing exists. I'm fairly sure a wouldn't want to be raised by one and I am now resolute that a "good enough" mother is a much healthier role model" K67/18.20-24

As is evident above, over-engagement (driven by perfectionism and guilt) reduces over time and the KSA students synthesises CBT with their identity and previous experience. There are no obvious aspects of CBT that are not absorbed, but there is a process of "Re-synthesis" (Seelye and Wasilewski 1979), blending the above in a unique way. One student reflects that her adaptability was important

compared to other peers, and this is present throughout the KSA group, reinforcing the "openness to experience" domain...

> "I have learned that I am adaptable to changes when being thrown in at the deep end and managing on little resources and procedures". K37/18.17-18

Having largely achieved becoming a Cognitive Behavioural Therapist, a number of the KSA students reflect back on their experience. They have managed to construct their transition to CBT therapist in their minds as a positive experience, for which they are grateful. There is a commitment to reflection, following from their positive experience.

> [IAPT] "has given me a greater awareness and appreciation off the positive things in my life…" K37/18.4-5

> "I also feel that given all of the adjustments I have had to make through this year I have coped with reasonable aplomb most of the time and have managed to reflect and work through my darker times quite successfully" K67/22.1-3.

4.4.9: Discussion – KSA

The objective of this aspect of phase 2 of the research was to develop a theoretical understanding of how KSA group members learn and transition to CBT**.** The shorter nature of this analysis and results section highlights a simpler transitional process for this group. The lack of investment in previous roles, lack of distorted expectations regarding CBT, and lack of dysfunctional coping styles from previous roles all facilitate the transitional process. There is some acknowledgement the role of coping styles in the literature (Ashforth 2000), but limited attention is paid to how the level of professionalization affects beliefs and coping styles. Other facilitating factors from the research include a positive attitude and a vigilant coping style, factors that are not present in the literature. There were no observable differences in external stress compared with other groups. There is an effective, refined challenging of inaccurate assumptions and a rapid absorption of new learning.

There is a significant generalisation of learning, and the transition process at the end of the year has approached completion.

4.5: Discussion and synthesis of findings, phase 2

The students undertaking the training in IAPT High Intensity CBT training clearly experience much in common, and some of these factors are described in Table 4.6 (below) The vast majority of students from all backgrounds describe the course as one of the most difficult things they have done, and that they experience periods of high stress almost universally, consistent with Bennett-levy and Beedie's (2007) experience. For the majority, they did not expect the course to be so difficult and the adjustment to this is perceived as difficult, partly complicated by professional factors. .

Table 4.6: Universal factors in transition across all core professions

Universal Factor	References
High levels of stressors present	C23/12.25-30, K26/8.18-21
Avoidance of CBT does not resolve through self-reflection	C21/8.20-24, N7/7.46
Self-practice important and a protective factor	K68/9.20-23, N7/7
Supervision important	C28/12.26-30, K40/7.1-5
Positive experiences with clients important	N1/14.4-27, C25/7.3
Integration of personality with CBT	C25/7.20-21, K36/9.23-24

Self-practice is recommended on the IAPT training course, and the majority of practitioners adopt this process, albeit in different ways. This process does not happen spontaneously for all professional groupings, especially where avoidance is a professional theme. Once self-practice does occur, it adds necessary depth and meaning to learning, and helps address the many stressors experienced by the student on the course. The learning from this self-practice generalises into other

areas of the students' lives for the majority and is recognised as valuable by the students, regardless of core profession. It is the self-practice that strengthens identification with CBT rather than other forms of learning.

Additionally, the freedom to integrate CBT with a personalised approach is important for many across professional groups, although this is especially important when professional identity is very high with a small number. Supervision is seen as challenging, but a generally positive experience. Most students, in addition to a positive experience in self-practice; also have a number of positive experiences with clients in the early stages of the course, which has a significant impact on both self-confidence, and on allegiance to CBT.

The significantly different models of transition in each core profession, however, are indicative of several significant differences between the core professions in the context of CBT. One example is that students from each core profession start from very different knowledge and skills bases, and perspectives on their own competence, and this is corroborated by part 1 of the research. A second factor is that each core profession adopts a different approach to a range of on-going issues on the course such as emotional expression, coping with stress, managing being observed and judged. A third factor is that different attitudes towards CBT are taught in different professional contexts, and this affects how it is learned. The fourth factor is that professionalization itself is a factor in both the learning of CBT and the nature of the CBT practice outcome for each core professional group.

The main differences between the core professions are highlighted in Table 4.7 and discussed in more detail below. Knowledge and skills related to CBT are assumed to be of a relatively high level in nursing and counselling / psychotherapy, and professional marketing plays a role in this process (Nursing and Midwifery Council 2017, British Association for Counselling and Psychotherapy 2016). Aspects of which skills are believed to be high vary according to profession. For example, mental health nurses believe that their knowledge of some of the educative aspects of the role gives them high levels of practice skills, and that the CBT knowledge and skills taught in nursing are largely

similar. Counsellors believe that they have high levels of practice skills because the counselling profession teaches that there are generic therapy skills that are transferrable between professions, and the extent of transferability appears to have been over-estimated by counsellors. The KSA group largely have a neutral view of their level of CBT knowledge and skills, with some personal variation.

Table 4.7: A summary of professional differences in learning CBT

	Nursing	Counselling	KSA
CBT seen as:	Aspired-to N12/5.26-28	Equal or beneath; conflicting with values C18/2.14-16	Aspired-to K35/12.4-5
Orientation	Task N2/3.8-10	Client C28/7.25-26	Generalised / therapy
Negative information	?Avoided ?Absorbed N1/5.10-12	Amplified C23/3.11-12	Filtered K36/3.11-13
Self-perception in CBT	Over-confident N60/8-10	Over confident C24/3.9-11	Accurate (Some brief over confidence at the very start)
Deconstruction of identity	Necessary N60/11.11-16	Necessary C23/13.5-9	Not necessary
Theory or practice	Theory first	Practice first	Integrated
Relevant Theories	DPR, reflective learning	Loss and transition, DPR, cognitive dissonance	DPR, attention management, personality factors
Pre-investment in perspectives	Nursing=CBT N8/15.3-7	Counselling <> CBT C18/6.2-3	N/A
Aspects of CBT not absorbed	Limited - ? Risk and complexity ?N7/5.22-6.3	Diagnoses, models, positivism in research, ?Flexibility and autonomy, client-centeredness c25/12.18-20	N/A
Coping	Generally Avoidant N1/13.14-18	Avoidant C21/3.27-29	Vigilant C67/2.25-29
Resolution	Technique Centred 12/13.3-5	Client Centred C21/12.19-20	Multiple Strategies
Protective factors in core profession	Professionalism, emotional distancing N5/10.14-15	Team cohesion, personal therapy C25/4.4-7	Limited supervision for some, self-reliance
Learning	Delayed	Delayed	As anticipated

Attitudes towards CBT also vary between the professions. Mental health nurses view CBT as aspirational (see 4.2.1, and this may be a motivating factor for them in progressing. Counsellors view CBT as either an equivalent therapy, or at times an inferior therapy, conflicting with counselling values (See 4.3.3). This may inhibit learning where these values conflict (Ashforth 2000). The KSA group are also strongly aspirational.

Professional trainings teach different ways of processing information, in effect filters through which the world is viewed. We have noted theories that suggest nursing is largely by default task orientated, and this has been confirmed in the data (E.g. 1.5 and 4.2.1). Crisis resolution (CBT self-practice) is largely applied in a technique-driven way, and this may be influential in mental health nurses' on-going practice. By contrast, counsellors centre their practice on responsiveness to the client, and the self-practice is undertaken emphasising the client's experience (sensing from within) in contrast to the nurse's "applying from outside". KSA students appear to have a more neutral stance on the filtering process.

Negative information is a perpetual feature of the training, from the students, from the clients, and from feedback from managers, teachers, and supervisors. Mental health nurses appear to manage this information either by avoidance or by absorption, taking it at face value. The latter is consistent with the "do it" orientation of technical rationality (Rolfe 1996). It may, however be problematic when negative information is overwhelming, as mental health nurses do not appear to be effective at consciously filtering out negative information. Counsellors in the sample not only fail to filter out negative information, they amplify it, exploring the emotions linked with it. This appears to deepen the negative experiences and amplify the effects of the emotional crisis. The KSA group are extremely effective at filtering out unnecessarily negative information, and actively screen for positive opportunities. This appears to be effective, and is not present in either of the professionalised groups.

Due to the high incidence of burnout in healthcare (see Wilcockson 2011), professions appear to employ strategies to prevent such occurrences. It has been known for a considerable time that mental health nurses use strategies such as emotional distancing, professional formality, and technicality, especially in inpatient settings (e.g. Bott 1976), which is confirmed in this study. Counsellors appear to obtain emotional support from colleagues, supervisors, and personal therapy. By contrast, CBT places an emphasis on the individual to resolve their own problems, sometimes using the supervisor as a guide. Professional distancing is disallowed in taped practice, and support of colleagues and support without resolution from supervisors is not available, forcing mental health nurses and counsellors to lose their safety strategies prior to being competent in CBT, and attempts to retain their safety strategies delay CBT learning. This does not occur with the KSA group.

There are a number of generic features where professionalization influences the transition rather than the core profession itself. Nursing and counselling students are both over confident in their CBT abilities at first (corroborated by part 1 of the research), and have significant skills deficits. A need to deconstruct their identity (and accept conscious incompetence) is present, and skills learning and reflection has to be forced through exposure and cognitive dissonance, and as a result learning is delayed, and incomplete in the case of counsellors, and possibly not fully complete in the case of mental health nurses. With the KSA group, no over-confidence is present, no de-construction is necessary. Reflection occurs spontaneously; learning is not delayed, and is complete. The absence of a core profession has functioned similar to a control group, in view of the learning functioning “as typically expected”.

The theoretical influences across groups include the Declarative, Reflective, and Procedural models (Chaddock et al. 2014), and CBT theory. In the context of Chaddock’s model, the links between personal and professional self were initially very weak in the nursing group, as were the relationships between theory and practice (I.e. the expectation of carrying out the practice

according to the theory). Reflection-in-action is also under-developed. Expectations and cognitive representations of the problems are also distorted by professional expectations.

With the counselling group, a strong emphasis has been placed on reflective and interpersonal processes. There is some reluctance to formalise knowledge and skills. Both the style and the nature of reflective processes taught in counselling generate expectations inconsistent with CBT, and also crowd out knowledge and skills in the initial stages of training. No distortion in any of these components is present in the KSA group.

The practical differences between core professions and also between professionalised and non-professionalised groups suggest significant differences in learning and coping. Counsellors additionally experience loss, which adds an additional burden for them into the learning process. This has implications for both theory and practice, which is covered at the end of this thesis.

Chapter 5: The practice of CBT by different core professions post qualification

Chapter 5: The practice of CBT by different core professions post qualification

Thus far, it has been noted that there are significant differences between the core professions in some areas of CBT skill and reflective ability prior to training, and that they have different transitional experiences in becoming an IAPT High Intensity therapists. In order to fully respond to questions posed within this thesis, it is also necessary to answer the additional research question "How does each core profession practice CBT?" which is the subject of this chapter. In particular, given that the different core professions start with different levels of skills, and transition in different ways and to different extents, answering the above question has significant implications for the application of the evidence base by different core professions

Retrospective research on transitions between groups, roles and professions indicates a range of different outcomes for the transitioners, from full absorption into a new role (substitution), to no adaptation to a new role, and a range of outcomes in between, (addition to an existing role, synthesis of roles) (Ashforth 2000, Seelye and Waselewski 1979) and this is dependent on a range of factors (new role identification, initial confidence and competence, the extent of the transition, value conflict, etc.) covered in chapter 4. There are three main studies into transition from a core profession to a CBT (IAPT) role; Robinson et al. (2012), Binnie (2008), and Chambers (2008). The latter two are primarily single self-directed case studies taking a broadly narrative stance, for mental health nurses (Binnie 2008) and graduate mental health workers, a subset of KSA (Chambers 2008). Robinson et al (2012) primarily take a retrospective view of the factors influential in the process of transition for mental health nurses. As their analysis is undertaken post-training, but based on their experience of training, the issue of retrospective inference is relevant. Phase 2 of this research overcomes this by analysing learning journals that are undertaken prior to the completion of the course, while the students are still absorbed in the experience, and thus more likely to report

authentic experiences. Robinson's research also assumes a process of transition to CBT in looking at the factors facilitating transition (such as the role of supervision). Phase 3 of the current research (focused on in this chapter) does not assume this. The nature of the current research question permits the researcher to allow for practices that may fall outside of standard CBT practice, (E.g. genericism, in counsellors, observed in phase 2) and seeks to assess the extent or completeness of the transition by discussing aspects of current practice in the context of the previous core profession.

Two focus groups of five counsellors and four mental health nurses were interviewed as the source material for this study, and reported on independently as two groups. The interview was recorded and transcribed, and then analysed using a thematic analysis methodology (Braun and Clarke 2006). The number of mental health nurses was selected from a group of nine, stratified to include at least one CBT therapist currently working in secondary care, in order to enable generalisation of the findings. IAPT roles within secondary care are different to those in primary care, incorporating more multidisciplinary working which would be more familiar to nurses. Five mental health nurses planned to attend, but one dropped out, and one was unable to access the venue but participated by an audio link. Within the counselling group, five participants were selected and all five attended. There were not sufficient numbers of consenting participants to undertake research relating to the KSA group and as there was less difficulty in the transition to CBT, this was not deemed problematic to the research.

5.1: Method

5.1.1: Theoretical orientation and rationale

The research question "How does each core professional group practice CBT?" does not have any available questionnaires or frameworks for measuring the question specifically. Indeed due to the lack of research in this area, rich, non-reductionist data is needed to describe the overall learning process and answer the research question, therefore a qualitative approach is required.

The framework to be used is thematic analysis. Thematic analysis is a qualitative research method suitable for reporting of data usually in a narrative form and from the perspective of those experiencing it (Viasmoradi et al. 2013) with relatively low levels of interpretation. This is consistent with the study which is trying to answer a straightforward descriptive question (without the need for a complex "gaze" such as lived experience (IPA), how information is communicated (e.g. discourse analysis) or model creation (grounded theory) etc.). However, there is no existing framework for measuring or recording these phenomena, and creating such a framework of theory or evidence (as in a quantitative approach runs the risk of "second guessing" what data is important) and has the potential to exclude key information from the subject's perspective.

Thematic and content analysis are often used interchangeably in research, however there are important differences (Braun and Clarke 2006). Content analysis has a greater emphasis on communication theory and also may identify themes based on the frequency of the occurrence within the data. This may mean themes are missed because the frequency is emphasised at the expense of the quality. It is typically used with written data, such as newspaper articles and reports, for example.

Thematic analysis overcomes these limitations. It generally both describes and to a degree inductively and deductively interprets verbal interviews, emphasising content and quality rather than frequency. According to Braun and Clarke (2006) the philosophical / epistemological approach

is broadly factist in the perspective of the data, and constructivist in its interpretation. Alasuutari (1995) describes factism as a form of empiricism applied to qualitative data, where the emphasis is on factual content of that data. Utterances, metaphors and other non-factual information may be used, but they are not assumed to be objective representations of reality. However they may be used collectively as a form of circumstantial evidence for that reality. There is some consideration made regarding the honesty of the reporting, and an emphasis on a pragmatic and common sense notion of the truth "out there".

Constructionism is a form of constructivist learning theory which argues that learning new information is best achieved by building together units of information that are tangible and real (Ackerman et al. 2009) This study aggregates units or themes of information into overarching themes, and these themes may be further constructed into sub-themes.

5.1.2: Ensuring quality of the research

Principles of qualitative validity have previously been explained in 4.1. Evidence for the trustworthiness of the research under the headings of confirmability, credibility, dependability and transferability is required (Shenton 2014).

Obtaining confirmability is difficult even under scientific conditions, but ensuring that the views of the participants are represented in the research is critical, To this end, the recordings of the focus groups were double-transcribed and reviewed for quality, and the transcript was made available to academic supervisors for quality checking. The researcher has also kept a reflective diary throughout the research examining his relationship with the data, see 4.1.3 and Appendix 10.

Credibility, broadly replicating internal validity, is achieved by:

- Retaining adherence to the most recognised, and consequently most replicable protocol (I.e. Braun and Clarke 2006), and being clear about the epistemological approach to the data.
- Understanding the cultural background of the participants. The researcher has previously worked in IAPT and been involved in IAPT training.
- Testing of the questions with targeted individuals prior to conducting the focus group (pilot).
- Triangulation of data. Data from phases 1 and 2 confirm some data in part 3, and they also confirm it across time period of collection, method of data collection and method of analysis.
- The participants were given an opportunity to comment on the themes after the themes were developed.

Transferability refers to the extent to which the study's findings can be considered valid in other situations. Although the nine individuals participating in the study all worked within the same NHS trust, they had previously worked in 4 different NHS trusts and had trained at 3 different universities. Therefore the research is suggestively independent of these factors. Also, one of the nurses worked in a secondary care IAPT service, so such views are represented in the analysis and results transferrable to that sector.

Dependability is enhanced by triangulation with the other two phases of the research. This is enhanced by the use of differing time periods, methods of analysis, and methods of data collection all broadly triangulating the research

It is also important within this domain that the results are those of the participants and not the views of the researcher. A summary of the researcher's perspective of his place / role in the research can be found in 4.1.3, with several pages of initial coding also included in Appendix 11 to place a context of his personal gaze, and where possible, acknowledge any bias and how it was overcome.

The nursing and counselling research was conducted independent of each other. This allows for individual themes of the core professional culture to be emphasised in “raw” form, whereas including both these groups together has the potential to dilute the experience of the core professional group, which could also dilute the data’s potential to answer the research question.

5.1.3: Procedure

Preparation

As in phase 2 of this thesis, the literature is only reviewed in a limited way prior to analysis. Again this is due to the need to understand some context, but it is important that the researcher does not “force” the data into pre-existing categories, although thematic analysis can be theory driven, this part of the research is data driven.

The research question at this stage has been deliberately kept general, to avoid premature reductionism and allow the relevant central themes and processes to emerge from the data. The precise nature of the research question and the method was delayed until the analysis of parts 1 and 2 of the research were completed, so that the research question could be formulated according to the data from this research, and also to, as a secondary effect, enable triangulation of key data from parts 1 and 2 of the research if appropriate. Delaying the research also enabled the researcher to consider how many groups to include. As the KSA group had relatively little profession-specific issues in transition, they effectively functioned as a transition “control group”, enabling factors that were generic to not be attributed to a specific core profession. As there were a lack of profession-specific issues in transition, and transition appeared relatively complete, there was no necessity to analyse their current practice, so only nursing and counselling groups were approached for this phase of the research. .

Ethical approval

The researcher obtained ethical approval from the appropriate university ethics committee, and also approached the ethics committee for one NHS trust. Although ethical approval was not needed, NHS trust (site specific) approval was needed, and this is contained in Appendix 7. Approval was obtained from the appropriate service leads at this stage.

Participants

Following consultation from the service leads of the NHS institution concerned, the researcher employed 2 gatekeepers for the nursing and counselling groups respectively. This was because the researcher has previously taught and supervised some of the employees and felt that a direct approach could cause undue influence. The researcher provided the gatekeepers with a covering letter, patient information sheet, and consent form (Appendix 6), and the gatekeeper contacted eligible participants within the service. Those willing to participate replied to the gatekeeper and this information was relayed to the researcher. Dates were agreed and all available participants (first 5 counsellors then later 4 mental health nurses) attended, one of the nurses attended remotely via a videophone.

Focus groups were used as this allows for individual opinions to be reinforced or rejected as a group opinion, which is not available to individual interviews (Morgan and Krueger 1993). It also has the potential to triangulate the research from phases 1 and 2 from a different perspective. It was noted in 2.4.1-2.4.3 that individuals may behave differently in identified groups. Therefore, if research confirms the same outcomes across different time periods and methodologies, this enhances consistency. The researcher conducted a semi-structured interview using Smith's (1995) protocol (See Appendix 12).

Data immersion

The researcher had a degree of pre-existing familiarity with the data. As the questions were semi-structured in nature, the researcher influenced the follow-up questions and summarised points of clarification, so took an active stance within the focus group itself. Prior to transcribing the data, the researcher immersed himself in the audio recording, listening through repeatedly and memoing important thoughts. Consistent with the factist stance, the validity of the data was considered, such as whether something appeared to have been said sarcastically, whether voice tone indicated whether an utterance was intended as a metaphor or to be interpreted literally. The aim of thematic analysis is not, of course, to analyse these ambiguities, simply to note them and allow that to influence the process.

The reading of data at this stage is important as it is not unusual that meaning can be lost or altered in the process of transcription between verbal and written forms. Note taking ensures not only that codes implicit in the verbal data are preserved, but also that the interpretation of verbal codes can be compared with the interpretation of written codes for mutual accuracy. Familiarity with all aspects of the data is key from the outset (Braun and Clarke 2006), and this was achieved in the present study.

Transcription

The data consists of two focus group interviews lasting 63 and 57 minutes respectively. There are a small number of brief periods of over-talking, and there are a small number of indecipherable passages within the first interview due to a presence of a mobile phone close to the recording device. The participants worked for the same service and were familiar with each other, assisting the honesty of the reporting, as did the fact that the data was confidential.

The researcher decided to undertake the task of transcription, but also had funding to have the tapes transcribed so decided to also do this and compare transcriptions for any different interpretations. The two transcriptions together did add more than the single recording in the researcher's view. This is important because transcription is considered a key phase of analysis where meanings are created (Bird 2005, Lapadat and Lindsay 1999).

A range of coding systems exist for recording verbal data where the process of speech is important, such as discourse analysis, however this is not deemed necessary in thematic analysis (Braun and Clarke 2006). However, convention appears to be that objective occurrences (significant external sounds, inaudible utterances, and over-talking, coughing, long silences) are recorded. In particular, these objective occurrences serve to retain and reinforce the original meaning or the verbal endorsements of the participants. Poland (2002) notes that punctuation can significantly alter the meaning of the data, and argues that attention should be paid to this to retain authenticity of the verbal account, and this was employed when transcribing the data.

Generating initial codes

It is important that all data is given equal scrutiny, even if it does not appear at first glance relevant to the research question (Howitt 2010). This is presumably not just to prevent data being missed, it also helps to overcome an expectancy effect where at this stage the researcher is effectively searching for data that they think may answer the research question. However, coding can be aimed at limited features of a data set, depending on the research question. Initial codes are, according to Boyatzis (1998) the most basic unit of data that can be conceptualised in a coherent way related to the subject. The initial coding overlaps with analysis as data is being organised and synthesised, although themes tend to be more specific at this stage.

As mentioned earlier in this section, coding in thematic analysis can be data led or theory led. The researcher intends the process to be data driven, however, an awareness of the theory and, having worked in an IAPT service previously, the researcher acknowledges a pre-existing knowledge that risks an expectancy effect. The researcher has undertaken a number of re-reads to ensure this does not occur

Theme identification and review

Once all of the data has been coded and organised into units and screened for "likeness", a process of searching for themes is undertaken. This involves "macroing up" the data to a more general level. The researcher used the "theme pile" approach, having each code written on a laminated card, and a range of different "boxes" were used as themes. A number of themes overlapped several categories, and were written out more than once. . As Braun and Clarke (2006) point out, generating a wide range of themes is desirable at this stage, and one piece of data may fit many themes and may appear contradictory. At this stage, there is no need for coherence between the initial codes. Some themes were easier to categorise than others, and a number of overlapping themes were created, to be analysed in the next section. The relationships between some categories was obvious and maps showing relationships between concepts were developed as a mid-level schematic. Some themes were very clear at this stage, some had sub-themes and some did not, some linked together and some did not, There was one very general category relating to transient processes in training and current unresolved issues in the counselling group, and also a "miscellaneous" category in both groups containing unrelated themes, which weren't dominant in the data but perceived to be relevant.

Once themes and sub-themes were identified, the themes were reviewed. There are two key tasks involved in reviewing themes. The first of these is reviewing the extracts deemed to comprise the

themes in order to review for internal homogeneity (Patton 1990). At this stage, data may divide into more than one category, some may not fit, or the category itself may lack robustness. On a few occasions overlapping categories are presented to this stage for review, to compare the extent to which they form meaningful categories. For example counselling practice 'retained' and "maintained" were both considered as themes, with a considerable overlap.

If the data fits with the themes, the second task of this stage is to ensure the themes are analysed to verify whether they accurately reflect the data as a whole. The contextualist paradigm, described in Johanek (2000) served as a relevant underpinning orientation to guide what determines whether the themes accurately represent the data. The data was re-read at this stage to triangulate for accurate reflection, but also to check if any additional data may fit into the thematic map.

At this point the themes and sub-themes were refined and named – reviewing the essence of what each theme is saying, and looking at the fit of concept with concept and theme to develop a coherent narrative (Braun and Clarke 2006). After this occurred, the researcher showed the provisional themes to the participants for comments, and then deleted the tape in accordance with agreed ethics protocols.

The data analysis and discussion is provided separately for each core profession over the remainder of this chapter.

5.2: Findings from mental health nurses focus group. Research question: "How do nurses practice CBT?"

This section contains the analysis and results of the mental health nurses' focus group. There were four members of this group, one of which was accessed by video phone. The period of the training was 3-5 years, and the participants had been trained in 2 different institutions. The age range was 29-56 (with a mean age of 41.25), and all were female, the latter being acknowledged as a weakness of the study. There was plenty of interaction between the participants, and sometimes longer quotes are included to capture the interaction and development of thinking within this group.

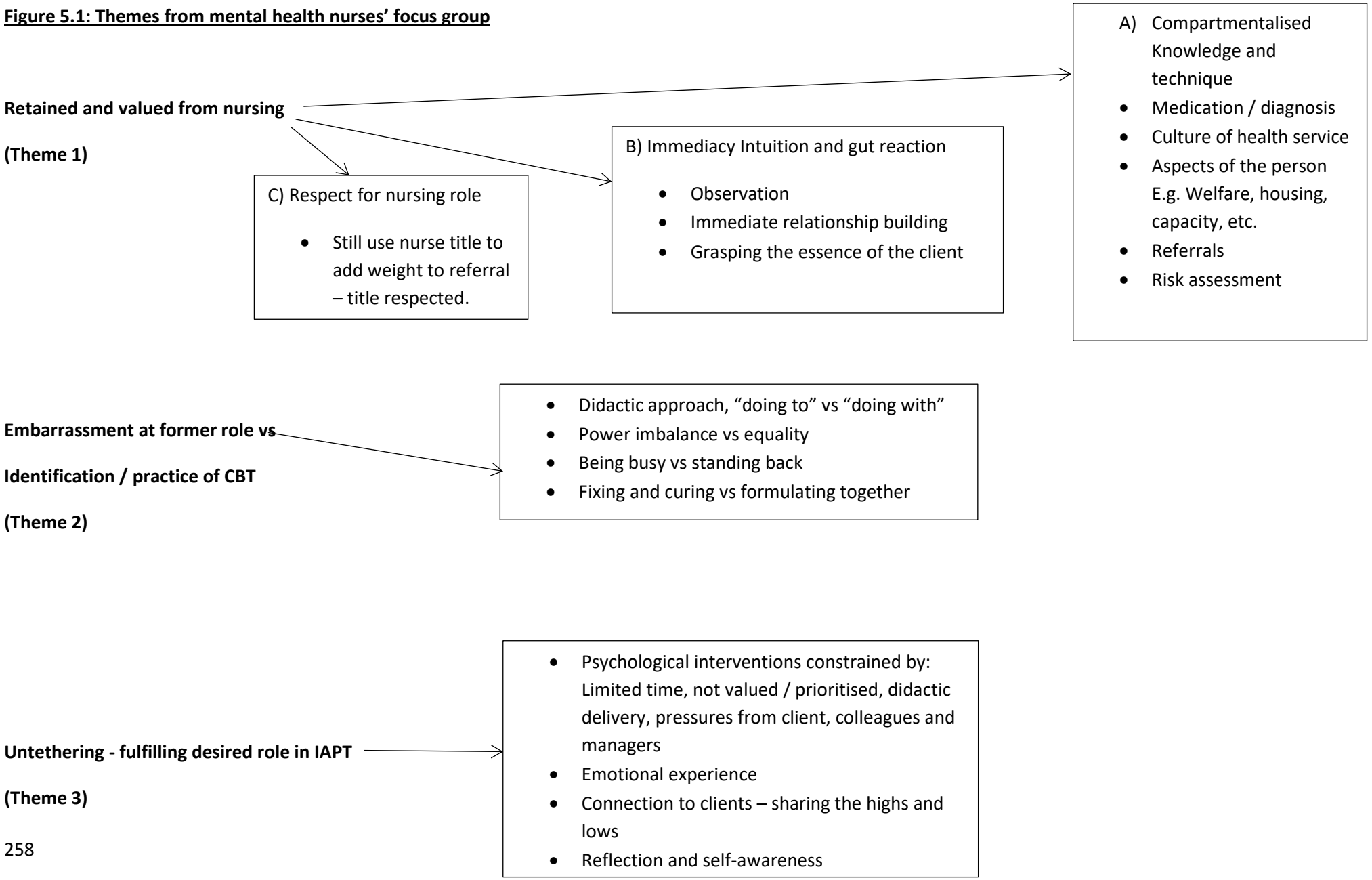
At the start of this chapter, a rationale for answering the research question "How does each core profession practice CBT?" was presented. With reference to asking the specific question, how do mental health nurses practice CBT? It is apparent that there are a number of features where there is variance from other core professions prior to the post qualification stage. In particular there are significant differences in skills to their colleagues in other core professions, a different way of learning CBT in some areas, and a universal acknowledgement that their learning was incomplete. Given the implications for the evidence base mentioned throughout this thesis, there are indications of a uniqueness in the mental health nursing's starting point for learning CBT, and also their process of learning. It is not unreasonable, therefore, that mental health nurses' practice will have some variance from other core professions.

Three main themes were identified, see Figure 5.1. The first theme "Retained and valued from nursing", describes features of nursing practice that remain valued and are still practiced. The second theme, "Embarrassment at former role / Identification and practice of new role" incorporates aspects of nursing that are no longer practiced, but also describe embarrassment from the mental health nurses that they practiced this way in the first place, and a strong identification with alternative (CBT) practices. This triangulates with theory from chapter 1.5 and research in 4.6

suggesting that mental health nurses generally wish to practice therapeutically, but are constrained from doing so by a number of factors.

The third theme “Untethering – fulfilling desired role in IAPT" seeks to encapsulate this point. Becoming a CBT therapist is considered to be a liberating process by the nurses, and some of the ways this occurs is described in this section. Inevitably describing problematic features of nursing causes theme 2 and 3 to partially overlap, however this is acceptable in thematic analysis provided the themes represent and communicate the essence of the data (Braun and Clarke 2006)

Figure 5.1: Themes from mental health nurses' focus group



5.2.1: Theme 1: Retained and valued from nursing

The first theme describes aspects of nursing that continue to be practiced as a high intensity therapist. This category is subdivided into three sub-themes – 1a) Compartmentalised knowledge and technique, 1b) Immediacy, intuition and gut reaction, and 1c) Legitimacy of (nursing) role. Throughout these sub-themes, these skills are added on to the CBT role and there does not seem to be significant areas of CBT not practiced where there is conflict

Sub-theme 1a: Compartmentalised knowledge and technique

Mental health nurses described a pride in some aspects of their knowledge and skills, many of which were carried forward into their cognitive behavioural practice. The compartmentalised aspect of this category tended to reduce theory and skills to specific areas rather than see the client's presenting problem as a whole. Chapter 4.3 highlighted that counsellors viewed a client through a wholist lens, whereas mental health nurses tended to view through sub-divided issues (medication, support, housing, etc.), which is evidenced in this theme.

The first aspect to be described within this group was knowledge of **medication**. In chapters 2 and 4 it was found that the relationship between nursing and psychiatry is a complex one. Although medication is an important part of the nurses role (Happell, Manias, and Pinikhana 2002), it is rarely used to describe the nursing role by mental health nurses themselves - their view of themselves bring typically expressed in more abstract terms. This focus group clarified that medication does remain important within the high Intensity role, and that at times even served as an anchor and a specific expression of the nursing role, confirming the model described earlier in Chapter 4.

Medication did not dominate former nurses' CBT practice, however they were willing to offer support and advice if the subject is raised, which was described as not uncommon. This included advice about the likely effects, side-effects, withdrawal effects, and reasons for prescription.

Previously, medication would be raised first by the nurses, and would be an important focus within a structured nursing intervention. In their current practice it was perceived as additional to the therapy and does not replace it in any way. Mental health nurses reported attachment to the broader context of CBT, and CBT practice dominates when the two were in conflict.

> P4: "I know medication well and always will do. I might be a bit old fashioned about medication, understanding what medication you're on and being able to provide that information for people, but also advice and that sort of knowledge if you really feel as though maybe what medication might be helpful, being able to think about contact their GP or psychiatrist if that's appropriate". (21-25)

A further aspect of the nursing role that was valued and maintained in their current practice is that of knowledge of the **culture of the health service**. As by far the largest professional group, it would be expected that embedded within their work would be the understanding of under-pinning knowledge required to function within the National Health Service in the UK. Practice skills are a natural consequence of this knowledge. Within this category is the policy and legal framework (e.g. patient capacity, Mental Capacity Act 2005)), awareness of expected behaviour and practice in an NHS cultural context, understanding of the day-to-day rituals, such as making a referral to another service, and an understanding of the clinical foundations of the mental health service, such as the diagnostic framework. Administration duties are often prioritised over clinical skills in nursing practice, (Higgins, Hurst and Wistow 1999), and in the sample, mental health nurses felt that they did this aspect well, and continued to do so in their IAPT role. They believed that they are still able to help other professionals in this area.

> P4: "…but I feel as though from previous experiences in nursing in different settings has that understanding of what different…if people have got other people involved or that might be helpful, understanding of what those services or other professionals might be providing and also experience different settings". (39-43*)*

This understanding of culture and procedure was important and was clearly used by the nurses in their IAPT role over and above the requirements of that role. This included familiarity and use of policies, referral processes, and an appreciation of the expectations of other parties when communicating with them.

Within the transcript below, there was limited direct mention of the client. The client is present in the mental health nurses' transcript, but the nurse appears to start from the **aspects of the person**, such as housing needs, medical / diagnosis needs, financial needs, etc.

> P1: "…in nursing we often had to consider various aspects of the person's life such as their health and their family and we had to have you know even look at things like their finances you know from housing right through to family life, although we were treating them as an individual we had to take into consideration all their different elements of them as an individual". (311-315)

Aspects of the compartmentalised knowledge are retained and valued in places, but again only under specific contexts where it arises or is obviously a significant issue. So, for example, if nurses had a familiarity with signposting for housing or financial issues from their nursing role, they were likely to continue this in the IAPT role.

The vast majority of mental health nursing takes place in a secondary care context, most typically with clients who have complex presentations (Severe depression, Schizophrenia, Personality disorders etc.), poor functioning, and high risk. All four participants came from a secondary care nursing background, but three of them were practicing CBT within a primary care setting. The mental health nurses stated that their knowledge of complex care was useful in managing the boundaries of appropriate versus inappropriate **referrals**, appreciating better where they fit into a secondary care model. Very few of the other professions had experience of secondary care, and it is not taught within the IAPT training.

Within secondary care, high **risk** is much more likely to be present (Self-harm, suicide, violence, child protection issues, etc.), and indeed is often an admission criteria for entry into secondary care, As a result, risk assessments are more thorough and more standardized in secondary care (to prevent idiosyncratic poor practice) than primary care and risk assessment and management is considered a major intervention.

> P1: "I think we have a lot of experience around risk, so frequently you know what might seem quite…on paper quite risky I think we have a good way of actually assessing that in the here and now sort of context, equally if we do feel that something is a risk that perhaps on paper might not appear to be we're very good at flagging that up also". (62-65)

Note that there remained a strong affiliation with the nursing role of risk management in the above extract, and this nurse tried to carve out an "expert role" within IAPT in risk assessment, as a number of the others also do.

Three of the mental health nurses stated that they believe that they have made the adjustment of managing risk from secondary to primary care appropriately, and that their knowledge of risk brought forward from nursing has been advantageous to them in their current role, as can be seen in the excerpt below.

> P4: "…but I think one of the things I possibly do slightly differently than some colleagues, but not everybody, is I do some planning around safety as part of therapy formulation". (83-85)

The excerpt above demonstrates an example of synthesis – adapting a previous role to a current context.

Sub-theme 1b: Immediacy, intuition and gut reaction

It was noted in chapter 2 that mental health nurses have quite a narrow focus to their practice, often focusing on only one aspect of the client and in terms of their immediate needs only. It was noted in chapter 4 that mental health nurses reported during training that their previous experience in this area generated difficulties for the nurse under a range of conditions in CBT, notably when required to collaborate with the client, deepen their emotions, or stay with a problem, not just react to it.

This focus group, however, notes that there are some advantages to this former approach, placed in a category "Immediacy, intuition and gut reaction" by the researcher. This category incorporates a number of features relating to the ability to recognize and respond instinctively to the immediate needs of the client, who may be experiencing high levels of distress. The term "nursing intuition" was mentioned by one of the participants and the researcher asked the group to clarify this term, the following exchange occurred:

> P2: "It's hard to explain isn't it"?
>
> P4: "Yeah. I think part of it is from different settings that you've been in…if you've come…I think part of it is if you've come from maybe experience or you've been in acute day hospital or sort of crisis teams of inpatients there is something about getting used to the…what the atmosphere idea you know within a setting or from individuals". (97-101)

This intuition is not a deep "felt sense", but an "ability to grasp the essence of something quickly".

Within this category, mental health nurses describe **observation** as important, both recognizing signs of formally identifiable problems, but also a gut instinct that something is wrong grasping the immediate essence of what is going on with the client. In the literature this is often attributed to recognizing incongruence that the presentation is in some way inconsistent with what is expected or typical (e.g. De Gelder 2006). Also within this domain is **immediate relationship building,** an ability

to build a rapport with people quickly and instinctively (which may involve humour), and also an **ability to grasp the essence of the client**, making quick, instinct led judgements that assess the client and any changes in their presentation. This continued to be adopted in the IAPT role, as evidenced in the excerpts below:

> P4: “I would bring in observation from the waiting room through to how they present coming in to the room”. (128-9)
>
> P3: “I think sometimes we may notice or pick up on things through the observation that maybe people who don't have the same kind of experience wouldn't see or make sense of in the way that we might”.
>
> P1 “It's even things like are their socks the same colour”. (135-8)

The mental health nurses view of themselves in this research as effective observers was congruent with their practice (Barratt 1996), and as a result, it is not surprising that they maintain value of this skill within the therapist role.

Sub-theme 1c: Respect for nursing role

There is one further area that is retained from nursing practice, and that is the nursing label itself. The majority of the group described continuing to use “nurse or “RMN” in some correspondence, especially in referral letters. The title “nurse” was deemed to be simpler to understand, and communicates an understanding of the functioning of the NHS and secondary care, possibly therefore adding some authority to the referral or a more rounded perspective and understanding compared with other professionals who were perceived as less likely to have worked in complex care:

> P4: “Sometimes we're not taken seriously or given the credit for what we have got because people see us as IAPT therapists rather than the fact we do have a background. Like for example if we're referring people on and we're recognising

> that there is problems, sometimes people don't take us as seriously because of IAPT rather than accepting we've got a background that can pick some of that stuff up and see those sorts of things". (638-642)

Mental health nurses appeared to have a pride in the fact that they have worked with complex mental health, and believed others will value that implicit knowledge. "IAPT therapist", by contrast was perceived as lacking the same authority or understanding. They explained that the use of the term "nurse" would prevent misunderstandings occurring as mental health nurses would be communicating with their referrers on the same wavelength.

5.2.2: Theme 2 - Embarrassment at former role versus practice and identification of new IAPT role

It has been noted in this section that there are aspects of nursing that are brought forward into CBT, however in all cases these aspects are perceived to add to or augment the CBT model. Where there is conflict, the CBT model has taken precedence, with data from chapter 4 suggesting that it is because CBT is a higher status profession, so there is a greater incentive to identify with it (Ellemers et al. 1990).

There are considerable aspects of nursing that are no longer practiced by the participants, and there is embarrassment and shame about these practices. "Dislike and shame from nursing" incorporates a sense of being **didactic,** largely having a one way relationship with the client. A number of mental health nurses expressed embarrassment at this, giving a sense that they knew and desired to practice differently, but got carried along with the nursing culture. A switch in emphasis to encouraging the client to learn for themselves has been fully adopted within the IAPT role

A consequence of a didactic relationship is that there is a significant **power imbalance** between nurse and patient. The nurse delivers care and the client passively receives it. According to CBT theory placing the patient in a passive role means that the patient is less likely to take responsibility

for self-directed delivery of care once the care stops being delivered by the nurse, creating a passive dependence or a likelihood of relapse. The nurse "does to" the patient rather than encourages and supports them ("does with") in CBT, and this is retrospectively spoken of in rather disparaging terms by the group as can be seen in the excerpt below:

> P4:" … whether it's perhaps a nurse is working on a medical model the interventions then are quite imposed and instructional so you know there's not the ethos that necessarily you know choice or how does the client want to approach this, but nurses being in the position where they're doing-to and their telling clients what they should do…"
>
> P3: "…I think that was one of the things that I noticed at the beginning when I started, this idea that because I'd been a nurse and used to almost telling people what to do or making suggestions or giving them advice whereas now more this idea of kind of trying to be collaborative and coming up with ideas together and you know getting them to learn from their own experiences rather than…and the fact that they actually learn a lot more from that than they do…" (180-190)

Mental health nurses described the process of moving from didactic to socratic difficult, as the didactic process was embedded within nursing practice and a firm habit which is taken for granted and unchallenged. Even after learning the socratic method and buying into its benefits, mental health nurses found themselves automatically being didactic in their approach without intention. Mental health nurses reported a determination to overcome this and a vigilance against relapsing into didactic practice.

> P2: "… I think the shift for me was from being didactic to socratic, it took me a little while to learn that and I know from my training that it's quite ingrained – in therapy you suddenly realise that you're doing it and telling people what to do again".(191-3)

One of the reasons that the didactic approach is "ingrained" (above) may be because the participants describe a lack of awareness of any alternatives to this approach. It has been noted that

the human and caring approach exists in theory, but awareness of this at any specific moment in time was relatively low, and it was difficult to apply in practice:

> Interviewer: "Were you actually aware of this as nurses when you were nursing were you aware you were being didactic and that there were alternatives to that"?
>
> P2: "I don't think I had that awareness, you just thought helping people, I know there's always that sort of (one word inaudible) advice and you try and help people find their way to solutions but you did, you did find other people pushing people in directions". (205-7, 211-215)

The above quote reinforces that mental health nurses believed they were practicing effectively at the time, but this is no longer the case. In spite of ideals of the profession, didactic is not only the default relational position, but nurses were largely unaware of alternatives to practicing in this way. An explanation of this from the literature is that the task discrete nature of the delivery framework in nursing precludes frameworks that promote lower levels of clinician control (Gijbels 1985).

The work framework for nursing is such that significant aspects of the role require immediate responses. Mental health nurses recall feeling **constantly busy**, and recognize that sometimes circumstances dictated this, but also sometimes this was self-generated. Nursing culture appears to encourage nurses to focus on the immediate or most pressing needs of the client or team without space to see the bigger picture.

> P2"… Pushing forward and "doing to" clients that's something I really don't like about nursing and coming away from it you get more aware of there is a mentality around nursing I suppose that was we always have to be doing and helping and getting things".(226-230)

The group describe that in spite of all the busyness, they retrospectively believe they were less productive as a result of a failure to reflect, plan, and learn from previous mistakes. Mental health nurses also mentioned that busyness and task focus distracts them from emotional discomfort and

the chaos of mental illness, and this is consistent with psychodynamic theory of institutional behaviour, discussed in 1.5.4. The practice of reflecting and standing back, although initially resisted, is fully adopted in the new role.

Mental health nurses not only experienced shame at their busy, narrow, focus, but also experienced some shame at their former attachment to the medical model, in spite of advantages described earlier. The unequal power relationship and the didactic delivery are strongly medically influenced, as is the expectation to **fix people**. This contrasts with a CBT view of improving symptoms and / or functioning of the client, and a counselling view of responding to the client's needs. Not only was there an embarrassment at the investment they placed in fixing people, identifying it as unhealthy and unrealistic, but they were also pleased to be free from the expectation from others to fix clients, and as CBT practitioners they felt they have license to challenge that notion if required. For example,

> P2 "... I had to fix people when I was a nurse and get them better, we don't, you're there collaboratively working with people to help them to get themselves better…"

> Interviewer: "…you said you <u>had</u> to fix people rather then you <u>wanted</u> to fix people, almost like there's a pressure in nursing that you have to do it that way rather than something you wanted to do".
>
> P2:"Yeah cos I think sometimes in reality you perhaps knew that some people would never move forward or never get completely better, but there was that need and people would be wanting that from you, the clientele patients wanting you to get them better, it's that help me and actually with IAPT it's not about that but help you help yourself. So yeah I think that's a nice bit that we've let go of, it's nice to have let go of that I think". (247-256)

Note that the nurse described feeling forced into a framework to fix people, bought into by the nurse, possibly by socialisation in training, reinforced by medicalisation of the role and task delivery, but also expected by the patients, confirming the literature and nursing model of practice described in chapter 2 and Figure 2.4. Being aware of encouraging the client to take responsibility in CBT enables the nurse to search outside the nursing framework, for alternatives to current practice

rituals. This was not available within the nursing role as there is no structure for independent reflection within that role (See section 2.4. and Figure 2.4). Encouraging the client to help themselves, as described above, was adopted by the mental health nurses in this group.

5.2.3: Theme 3 – Untethering, fulfilling desired role in IAPT

This theme describes a desire by mental health nurses to practice, both process and content, in more therapeutic ways as CBT does. This desire has been longed for much of their nursing career, and has been practiced sporadically, however, a number of constraints have made it not possible to practice consistently, and in some cases learn properly. Some of these constraints have been formally and informally imposed by the nursing culture, psychiatrists, managers, and patients, although there are examples of the nurses maintaining the constraints. Some of the practices mental health nurses knew did not fit with their desired way of working, but they did not have the language to describe the problem or have knowledge of alternatives.

Nurses were untethered from doing psychological interventions, previously being constrained by a range of factors. One of these factors is a limited time available. A proper psychological intervention involves discrete time "set aside" for planning, delivery, and reflection for such an intervention. Mental health nurses described being regularly distracted by competing needs, especially in view of the broad context of their work (also mentioned as a positive factor), which focused on task completion as identified elsewhere. Nurses noted that non task focused work, without immediate results or with a need for extracurricular activities such as planning and reflection, are not valued by colleagues. In addition there is no framework in nursing to accommodate the delivery of the intervention, and sometimes a lack of skill, and a lack of an ability to carry the intervention through in future. P4 (below) clarified that the framework for understanding the client was different in nursing and this restricted the extent to which true psychological interventions could be undertaken:

P2:" I don't think when I was nursing there was that opportunity to really work with the individual, it very much was we were at work, group activities, we did spend time with patients individually but very limited time and without the skill set to actually do what you wanted to do in named nurse work - how they're getting on, so it's more reflective of you and how your progressing, mental health monitoring".

P4: "My view is that the individual…often the individual approach that comes from a nursing point of view is giving our understanding to a client about what's happening for them, rather than what we would do now which is spending that time to help someone be able to tell us what's happening". (292-300)

There was evidently no framework within the nursing role to step outside of the immediacy and task focused aspects of the role. There appears to be an unstated and unquestioned prioritisation of immediacy and task focus, and there is also an informal process of ensuring adherence to this process by other members of the team. Note that time with the client tended to be as much for the benefit of the system (health monitoring, checking risk) as it was for the client.

P2"…having an hour with each person individually would have been unheard of…" Interviewer: "…what would stop that as a nurse"?

P3: "There would be other pressures, there would be other things that needed to be done, management, and making sure that other things were happening and yeah just…"

P2: "…seen as quite an inconvenience…" (327-333)

The notion of a task driven lens also inhibited psychological interventions in two ways. One of these is that it limited a true psychological intervention due to an unstated goal of reducing emotions. Also, the busyness and the need to consider compartmentalized knowledge also restricted delivery of interventions, fragmenting the patient into their individual needs rather than considering them as

a whole. The compartmentalised knowledge is considered much less of an issue in psychological therapies as the therapist only deals with psychological well-being and all other domains are generally assumed to be the responsibility of the client. This may also reflect differences in approach between primary and secondary care as well as between the professions.

> P1:" …I guess because we're working in a slightly different way, we're concentrating on the individual psychological well-being, all the tools that we're using psychologically based, whereas in nursing we often had to consider various aspects of the person's life". (309-312)

Nursing was described by the participants as having limited autonomy in practice, largely having either to respond to events or fulfil role requirements with limited scope for planning and reflection. Psychological interventions were historically viewed by nurses within this framework:

> P2:([In nursing]" I think there's definitely a less autonomy to work with clients, with day service we did do therapeutic activity and some of that was…things like anxiety management course and relaxation training so a bit of CBT coming into the work, basic…"
> Interviewer: "…so based on that did you think you knew CBT when you came into…"
>
> P2: "I thought I did and when I did my training I thought oh my gosh there's such a lot more that I didn't know so it was massive learning".
>
> P4: "And I was similar that I came from a day hospital background that we did CBT groups but without the individual formulation that went with that, so it was very much delivering materials and I supposed quite in an instructional way really". (273-5, 277-286).

Note that, as mental health nurses, CBT was perceived from within the nursing framework and only parts consistent with that framework (e.g. education) were practiced, whereas features outside of the nursing framework, such as individualised formulation, were not practiced.

The task focused "get things done" attitude fitting within a managerial and psychiatric positivist paradigm was not just present within nursing culture, but it was described by some participants as being reinforced by older, prototypical nurses with managerial and professional influence, and the social pressure had a critical role in limiting psychological interventions. The implicit criticism was not necessarily overtly reinforced by everyone, sometimes the behaviour was implicitly frowned upon:

> P3:" …when I worked as a nurse, particularly in the NHS, the people around me, the people that were managing me were much older and didn't have the insight, couldn't see what you wanted to you know if you wanted to do stuff, so there was a lot of barriers I think around it, even if you wanted to try something different it wasn't necessarily looked on in a positive way". (265-268)

The role of role models and prototypical practitioners in CBT was explored in 2.5 and confirmed in the phase 2 research in 4.2, and is significant again here, especially in the context of supervision. The availability and influence of such practitioners contrast sharply with the above.

In the nursing role emotions are not overtly discouraged, however, there is **no room in the role for an exploration of emotions** with the client. The closest this came to occurring was when mental health nurses explained their understanding to the client. The delivery system in nursing prevents them from experiencing emotion, which they aspire to do with clients. The group wanted to help and share the experience but were unable to do this:

> P3: "I mean certainly from my perspective I don't think we would have been encouraged to show emotion or expressed any of that sort of thing when I was working as a nurse…"
>
> P2:" I mean I think it was there wasn't a lack of empathy".
>
> (Approximately 5 words unclear)
> P4: "… I think you get less emotional and you get more part of the delivery system you know…" (351-2, 357-9, 360-1)

The compartmentalised knowledge also inhibited emotional experience and expression, particularly by compromising breadth for depth. This contrasts sharply with CBT where emotional expression is encouraged and mental health nurses buought into the CBT process fully and describe feeling liberated (See also 4.2.8):

> P2: "you are very involved in the person, a very whole person in terms of housing, family, finances so your picture of them but that pictures so broad that you don't get involved in any single one in depth…"
>
> P3:" I suppose the nature of the therapy as well with CBT is that actually what we're doing is encouraging people to express their emotions but then that becomes part of you too doesn't it, particularly with certain types of therapy often that emotions in the room and you're part of that". (372-4. 378-81)

This liberation helped the mental health nurses grow, and also reinforced the aspired-to attribute to working with the client. This appeared more real for the nurse, and also **more connected to the client**. This represented a genuine break from previous ways of working. Being "in it together" which led to more job satisfaction

> P1:" It [nursing) felt a lot more superficial rather than therapy, therapy feels very real to me and obviously hopefully for the client it does also and so it takes on a different meaning, it creates slightly different emotions within".
> P3: "I guess while I am thinking about it when we're in therapy with people we're working on things together, so we feel the highs and the lows of that therapy intervention, whereas I'm just thinking about what it was like say on a ward with nursing interventions, it's very much I suppose then the patients can feel better alone in their highs and lows because it's all very much dictated by the expectations of medicine and what the nursing care plan says whereas in therapy you're in it together so perhaps a different dynamic". (406-415).

The mental health nurses sensed that they had been "missing something" for some time demonstrating new-found **reflection and self-awareness**. Nurses appeared aware that, for example, clients may have felt alone in their "highs and lows", perhaps because they were hoping for and expecting this based on the ideals of training, but service delivery precluded

this. This gap was filled by CBT, and relationship building with the client was adopted at a considerably deeper level than in nursing.

Supervision is a further sub-theme that was also not able to be carried out effectively within a nursing role. Mental health nurses talked about nursing supervision in rather disparaging terms, seemingly because reflection was a luxury that there was no time for because things need to be done.

> I: "how's supervision in IAPT compared to supervision in nursing"?
>
> P4: "Very different".
>
> (Laughter)
>
> P2 "We get it"! (Laughs) (450-454)

When nursing supervision is undertaken, it is often delivered in a protocol driven, management focused, task orientated, and didactic way (Burrows 1994), which has the tendency to suppress emotional expression.

One of the more reflective members of the focus group noticed a parallel process between supervision and practice in CBT and nursing – the didactic and prescriptive nature of supervision delivery in nursing mirrors nursing practice:

> P4: "It's interesting how supervision in nursing models again the way it functions as a nurse but supervision in nursing is also very directive and restrictive, there's a lot of expectation and likewise the difference between supervision in CBT, it's collaborative, it's socratic, it's about us reflecting and finding our way so yeah". (473-6)

There is a sense of being encouraged as practitioners to consider what is best in CBT supervision, rather than being told what is best in nursing supervision, which limited professional judgement. The nurses appeared to fully adopt and value this independence. The transition process to this

independence was difficult though because the expert role was disallowed in training before alternative coping strategies are provided. Emotional closeness in the new role exposed the nurses to difficulties, which were, in the absence of emotional distancing, managed initially by supervision and eventually by self-reflection.

> I: when that shield [emotional distance] is taken away in IAPT what happened I suppose and maybe what replaced it, how do you cope with high levels of emotion now and how is that different?
>
> P2: "I went running to my supervisor (laughs) certainly yeah I think it is needing to talk about it, I think there's much more need and desire to talk about what's happening in therapy, about the interactions and how it's making you feel because it does bring up emotions. Especially certain things can touch you can't they, like traumatic events and the like, so being able to find that support is important". (423-9)

5.2.4: Summary

Considerable areas of nursing practice were willingly dropped during IAPT training, although this was observed to be a complex process in this chapter and in chapter 4. A longing by the mental health nurses to practice therapeutically has been realised. Some limited areas of nursing practice were retained; however, they tended to augment and add to, rather than prevent application of, the CBT role. The first example of medication clarifies this process – that it was only raised if the client so desires, and the general focus is on the delivery of therapy. Mental health nurses valued their skills in immediate responsiveness, and appeared to be skilled in this domain.

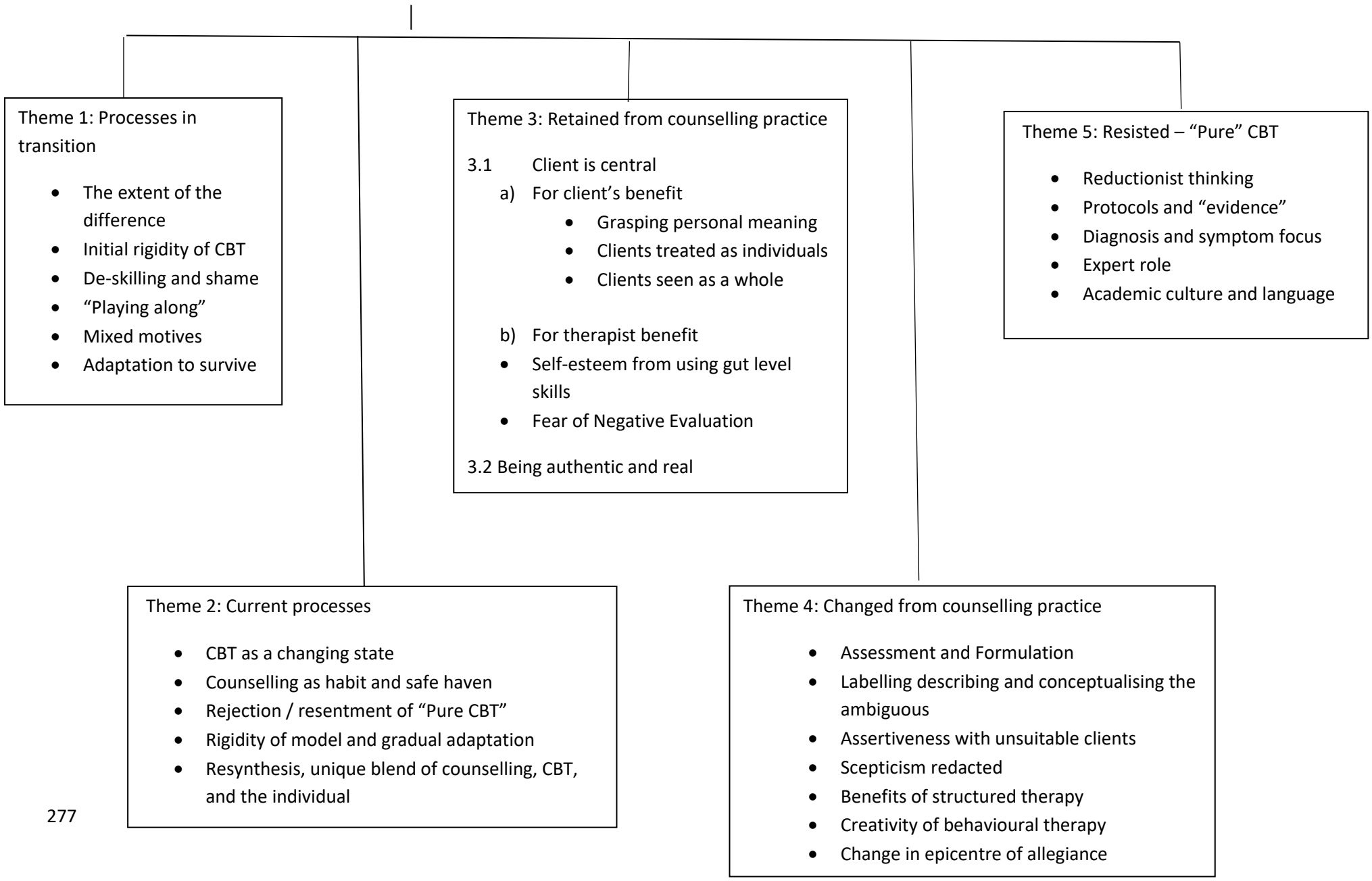
Whilst nursing identity was largely lost, it was often used to demonstrate to other professionals that they understand complex clients, aspects of health service culture, and also the needs and requirements of different services. There were no aspects of CBT that were not adopted, although aspects of nursing "add to" the CBT role. Thus retention of the "nursing" role is only retained which is adds value to the CBT role.

5.3: Findings from counsellors focus group. Research question "How do counsellors practice CBT?"

This section summarises the findings of a 57 minute focus group with five counsellors. The aim of the focus group is to understand how the counsellors currently practice CBT. A summary of the findings is described below. Five main themes emerged from the data, each with a number of sub-themes. These are outlined in Figure 5.2.

Whilst theme one does not directly link to the research question of how counsellors currently practice, it is an important theme in that it re-emphasises (triangulates) data from phase 2 about how counsellors transition into the CBT role. Thus this theme has been retained.

Figure 5.2: Overview of counsellors' themes



5.3.1: Theme 1 - Processes in transition

The process of transition will be discussed first due to the fact that it corroborates and clarifies aspects of phase 2 of the research, and acts as a bridge for understanding the context of current practice. This theme is subdivided into six sub themes.

Sub Theme 1.1: The extent of the difference's impact on current role

Counsellors perceived the gap between the roles of counselling and CBT to be one of the most significant factors causing a difficult transition. It is unclear whether this perception of CBT at the time was consistent with the practice of CBT at that time. Language interfered, as did a lack of a familiar structure within which to work. A stage of bewilderment was described by one student as they became aware of the contrast between the roles

> P4: And I think I'm there I think at the beginning I felt really disorientated, I couldn't quite get how to hold these counselling and CBT together and I remember walking out going it's not counselling, that's not counselling and I remember one of my colleagues ahead saying it's not counselling…it's something very different. (168-171).

Sub-Theme 1.2: Initial rigidity of CBT

This initial process of CBT was a little easier for counsellors who were familiar with it, but all the counsellors noted or confirmed that the rigidity of the application of CBT was problematic. This confirms data from part 2 of the research and also data regarding which aspects of counselling practice were retained, presented in 5.3.3. It appears that counsellors expected to "bolt on" CBT to their existing skills, but, initially at least, this was not permitted in the classroom or in practice, and there was perceived to be control over this by lecturers, managers and supervisors.

> P4: "I've always worked integratively anyway...so the thing I really struggled with at the start was the structure...actually being asked in supervision to drop all my

other skills. You know I have to be a CBT practitioner and I have to forget my previous trainings..." (174-5, 178-9, 180-82)

Sub-theme 1.3: De-skilling and shame

Dropping existing skills prompted an initial feeling of being both deskilled and unskilled unexpectedly, and there is shame and frustration attached to this. Counsellors expected to be supporting other students whereas in practice they were finding themselves behind other students due to reluctance to practice in the way specified initially. The shock aspect of this, along with a previous expectation of support and a freedom to be open with emotions, triggered an interpersonal crisis in most. There was also an objectively "right" way to do CBT as experienced by the counsellors in training, and fear of negative evaluation, not objectively experienced in counselling, was activated during CBT training:

P4 "I was worried about is what I'm doing in CBT and am I any good at it or actually I think I might be quite bad at it and when I was anxious about those things I don't think I was giving very good therapy" 275-278

Counsellors confirmed that a process of unlearning and re-learning occurs. It is noted the shame and high levels of emotion associated with this in chapter 4 and this chapter These emotions appear to be linked to a belief, reinforced by the counselling profession, that all therapies are fundamentally the same and that therapy skills are transferrable.

Interviewer:"…do you feel you need to unlearn stuff"?

P1: "Well I did actually, I did feel like I had to cos I felt like I was talking two different languages [inaudible due to over talking 00:42:3]) which I didn't understand the letters of the alphabet let alone anything else. So yeah…"

Sub theme 1.4: "Playing along"

The unlearning and re-learning was not common to all areas of practice. At times during training, and afterwards during formal contact with peers, the counsellors described avoiding learning / integration, having to "play the game" or "play along" to manage others expectations of performance within the role. This did not always occur, but when CBT practice was not fully adopted or counselling practice retained, this tension existed and may not be fully reconciled.

A prime example of this is supervision. Counsellors desperately wanted to talk about personal experience of self and client in supervision. Although there was an emphasis on the client, counsellors considered it insufficient for their needs, and adapted to a ritual of presenting a client in a structure that is doubted:

> P4 "...how will I present this in supervision, how will I present as a case discussion, what is it that I'm doing with people, am I actually following my role. So that is a conflict for me constantly (murmurs of agreement from others)" (89-91)

Sub theme 1.5: Mixed motives

One student explored the conflicted motivations within oneself for undertaking counselling and CBT training, noting that she was attracted by very different reasons, which, while they can be kept separate conceptually, in practice they overlapped and conflicted:

> P3: "And I chose counselling through passion and I chose CBT for profession so they were very different things when I was trying to work out how to merge those two".
> I: "Do they both add something"?
>
> P3: "They do".
> I: "Is that universal experience"? (Generic yes's) (373-8)

Sub-Theme 1.6: Adaptation to survive

One final point about this category is that there was a reluctance to give up the right to practice according to their perception of the needs of the client, and adopt the CBT model. However, there was at least some integration, and, as suggested in phase 2, the decision to partly integrate was not made out of choice, but out of necessity, to fit in and be accepted within the dominant therapeutic paradigm.

> (Discussing colleagues who only had one therapeutic model i.e. CBT)
>
> I: "So because you've got another model you don't feel the necessity or you didn't feel the necessity to kind of attach yourself to it in quite the same way"?
>
> P3:" Well I was opposed to it (laughs) even though I opted to do the training, but yes there's a process of change and integration isn't there that happens I mean it has to happen as a matter of surviving really I think".(477-481)

It is evident that the transition remained incomplete, and the counsellors adapted to the language and the culture where it was perceived as helpful.

5.3.2: Theme 2: Ongoing and unresolved processes in current CBT practice

This theme incorporates on-going processes and conflicts in managing and reconciling the counselling values with the on-going high intensity role, and has 5 sub-themes. The process of reconciliation between counselling and CBT was an incomplete one, and this ongoing conflict becomes an equilibrium state ('liminal space' Croft, Currie and Locket 2015b, see chapter 2). This conflict regarding CBT and counselling has existed for many years (March 1997, House 2012)

Sub-theme 2.1: CBT as a changing state

It is of relevance to note that CBT increasingly incorporates a broad range of therapies and a broad range of skills and processes, perhaps broader than IAPT, and it has also become a more integrative therapy since many counsellors have trained in CBT. The researcher noticed that the counsellors appeared more relaxed with practicing CBT over the years, and wondered whether CBT itself had changed and whether that had impacted on the way they practiced therapy. The increasingly integrative ethos of CBT (Incorporating gentler processes) has clearly assisted in resolving some conflicts not resolved from training. In particular, counsellors felt more comfortable identifying with CBT and using it as their frame of reference, even if not agreeing with all of it.

> P4: "they started off maybe very structured and very focused and struggled with what they were being presented with and they've had to and they've had to bring in the other stuff to you know yeah integrate into it".
>
> P3:"Beck actually said didn't he in his recent article, he wrote an article didn't he and he said it's one of his regrets that it was so prescriptive at the start and he said actually he's really, really happy that mindfulness ACT and those are coming in and over the years that's what he's learnt as well".
>
> P5: "I think it just gives permission to know that it's ok to be flexible and CBT's have had to bring in other stuff to make it more workable. And sometimes it just feels like it semantics and it fits into maybe some of the other Rogerian stuff and the core conditions and stuff going back to that sort of stuff…"
>
> P1: "…but it's got the CBT watermark (yes's)…" (550-8, 561-570)

Counsellors described practicing a form of CBT that is broadly in harmony with counselling values. Precisely what is practiced (and not practiced) will be described shortly, but important processes included responding to client's needs, and being authentic. Also, the therapeutic relationship remained important, and indeed necessary before CBT interventions are undertaken. Although the counsellors experience ongoing role conflict as an equilibrium in their high intensity role, CBT itself has moved in ethos towards the counsellors' position, partly reducing this conflict.

Sub theme 2.2: Counselling as habit and safe haven

In spite of CBT becoming more of a frame of reference for the counsellors, there are some lapses back into counselling practice. This appears to be due to residual habits rather than an intent to avoid CBT practice, although, as will be explored shortly, there are some issues of identification and practice that remained for the counsellors.

> P4: "I think if some people still have one model that they work with and that's a CBT model it's what they have to fall back onto so there's still that…but I think…"(Pause)
> I:" …you've found yourself falling back onto things other than the CBT model at times?"
>
> {Agreement X 3}
>
> P6:" …I think I'd find work really boring and not very creative if I was this idea about purist and just doing the set third session of GAD* and therefore I need to do this, I don't think I could get up in the morning".(503-511)

*GAD= Generalised Anxiety Disorder

Sub Theme 2.3: Rejection and resentment of "pure" CBT

The example above also confirms that there is an on-going resentment against "pure" or "purist" CBT, mentioned 10 times in the interview, in particular, sticking rigidly to the research, and / or model. This was not fully conceptualised by the counsellors, but it appears to be defined by the distinctive characteristics less present in other therapies. Purist CBT was viewed as a lesser therapy seemingly because of the ideological stance of the counsellors, that diversity, richness and experience is to be encouraged, and conceptualisation, theorising, and standardisation are seen as contrary to the humanist ideology common in counselling. The notion of "pure CBT" is explored further in the "resisted" category (5.3.5).

Sub theme 2.4: Rigidity of the model and gradual adaptation

It was not the content of CBT that the counsellors struggle with, but the rigid sticking to one model. This applied equally with other therapeutic models. One participant described feeling very similar attending an integrative counselling course with a majority of purist person centred counsellors as colleagues. It is implied that she believed that the transition is initially easier for those with no alternative frameworks (purists), but they would have to make adjustments later when purist models don't work or don't suit them:

> P2: "this was a masters so he taught these people at degree level and they were person centred and my god were they person centred so actually things that I just thought were reasonable to contribute were like I was the devil so actually I think is that something about you know that we've already done something... But they certainly shift, I've noticed a shift in people in a couple of years."

> P4:" It's like learning how to drive, you're doing it to pass and then as soon as you pass you start to develop your own way…" (overtalking) (435-7, 445-8)

Sub theme 2.5: Re-synthesis – unique blend of counselling, CBT, and the individual

The process of integrating CBT and counselling was described on several occasions during the interview. The fact that it was integrated appeared to be important to the counsellors at a personal level, and in many respects the process went beyond simple integration to what Brislin (1980) describes as "re-synthesis", that is, combining 2 or more traditions in an original way, so that the product is more than the sum of its parts. Counsellors brought their personal and professional selves, their values, history and aptitudes into the process of synthesis:

Counsellors described this process as broadly fluent, there was no longer a sense of chopping and changing between CBT and counselling techniques, but a seamless transition that often wasn't even consciously noticed by the counsellors:

> P4: “It’s definitely not like I’m gonna put my counselling head on for ten minutes now and then I might put my CBT therapist head on it’s definitely much more integrated”.
>
> P6: “Yeah it’s more integrated and eclectic sometimes as well (laughs) nature of CBT…”
>
> P5: “…interesting it’s become more free flowing as well, before it was slightly yes I’m putting my counselling hat on but it seems to just flow automatically, I wouldn’t know the distinction myself sometimes I don’t recognise the distinction”.(413-418)

This theme has introduced the current processes relevant for counsellors in application of their identity and practice. An adapted form of CBT is applied, and there is a reasonably good identification with generic, but not with “purist” CBT. There is a process of synthesising CBT, counselling, client context, and personal factors in an original way. Since originally adopting CBT, CBT has become broader, allowing a greater range of interventions which has had an improved fit with those from a counselling background. Although many conflicts still existed for CBT counsellors, these problems are dealt with from within a CBT framework.

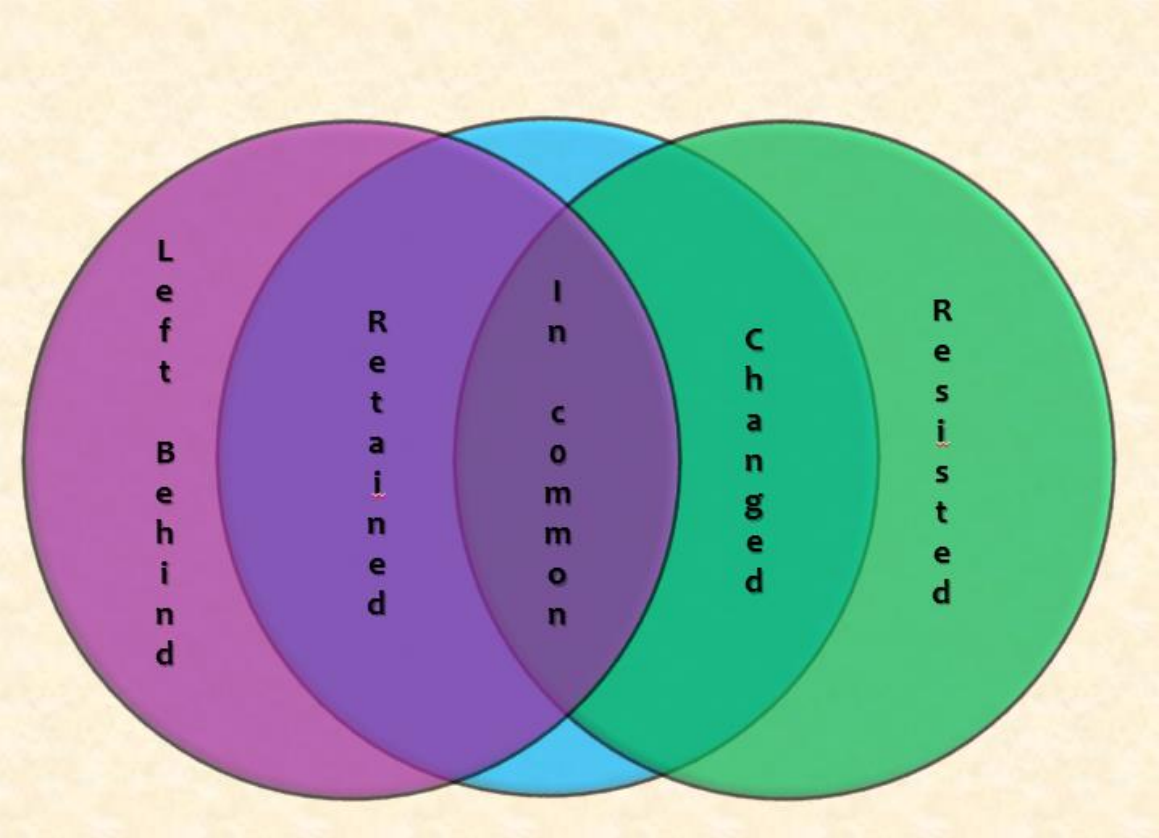
> P4: “I’m really interested to know what research keeps telling us because research drove all of this and obviously we all know that the research was and is done shapes outcomes but in an open and curious way I’m interested to know what more we learn about what helps people to get better as a result of the different ways that we’re working and how we measure it which isn’t just about do you treat social phobia in a X number of sessions but just about actually what helps people...”334-639.

The final three themes relate to each other in a way best explained by using the notion of a Venn diagram (Figure 5.3). Counselling is represented by the left circle, and CBT by the right circle (not absolute, for identification purposes only). Prior to the training, there were many features “in common”, but also many different features. CBT as practiced by the counsellors (middle circle) incorporates features of counselling “retained” from previous practice but not part of CBT practice

(Theme 3). It also includes aspects of CBT which were not previously practiced and have been adopted ("Changed", theme 4). It does not include some aspects of CBT typically expected to be adopted by CBT practitioners ("resisted", theme 5)

Figure 5.3: Counsellors relationship with CBT

Left circle (counselling) Middle circle (CBT as Practiced) Right circle (Pure CBT)



5.3.3: Theme 3 - "Retained" from counselling practice

The category "retained", incorporates features of counselling that are "not CBT", that continue to be valued and practiced in spite of being a CBT therapist. This category often does not represent absolute differences, but differences in extent, importance, and emphasis. For example, CBT therapists consider the therapeutic relationship as important, but counsellors consider it central to the therapy (Worden 2008). The category is further complicated by the fact that CBT itself appears to have been changing since the counsellors completed their CBT training. In short, CBT has become broader, incorporating more ideas that may be compatible with counselling, and a broader range of approaches, such as the "third wave". The excerpt below came out of a discussion about what counselling values remain important:

> (What values from counselling remain important?)
>
> P3: "I think still compassion yeah and that's why I think I find the third wave quite attractive, the compassion with the client and really sort of being present with them I think, I think that feels really quite important". (252-254)
>
> P1: "CBT has been changing, that makes it more workable". (526-7)

The overall theme of the retained category is that the counsellors broadly practice a version of CBT which fits with and works for them, based on their past experience and personality, and significantly influenced by their profession. This was a partial resolution, but there were some continuing tensions with expectations in supervision, expectations of service delivery, and peer pressure:

> P4 "...it's like I've integrated CBT into me whereas I felt I had to do it the other way round before, felt really deskilled at the start but now…"
>
> P3 "…it's been absorbed now and I feel more confident in what I do and being able to justify what I do even though there's that conflict with IAPT but I feel more confident in saying well no actually this is ok, so I'm a bit more permissive but yeah it's interesting integration the other way round". (383-5, 386-8)

The presentation of the sub-themes is more complex in this category, with the "client is central" sub theme dominates this theme, and has a further two levels of sub-themes attached to it.

Sub Theme 3.1: "Client is Central"

There is one major theme and one minor theme in the "retained" category. The major theme is the centrality of the client in the therapy. This can be sub-divided into a further 2 categories – for the client's benefit and for the patient's benefit.

Sub Theme 3.1a: Client is central - for client benefit"

The most consistent theme within the category "Retained-centrality of client-for client's benefit" is the notion that, due to the client being central, there is a duty on the therapist to respond flexibly according to the clients need. The flexibility, the ability to vary strategies according to a "gut response" of client needs, is more important than any one strategy or approach, including both humanism and CBT. Attempts were made to merge counselling and CBT, but the process wais not complete.

> P2: "I might tend to kind of go with the client obviously and obviously have a CBT framework in my mind but it might be that I use it more collectively as a toolbox (ums from other participants) and whatever feels pertinent at that time..." (32-34)

Sub Theme 3.1a-1: Grasping personal meaning (of client)

Personal meaning for the client is considered important by the focus group. Although this is important in CBT (Cognitions must be authentic to the client), CBT perhaps views the

process through a lens of treating problems rather than knowing the client. This phenomenological emphasis remained significant for some:

> P3: "I suppose in the moment, the client attaches the meaning that they attach and I think that…and maybe this is...I have to take on board you know my poor practice maybe of CBT in certain respect that actually I struggle with those things within offering CBT because there's a sense that I have to be the expert and actually that's (laughs)…doesn't sit very well…" (260-265)

This was a source of ongoing conflict in the high intensity role where personal meaning is strongly identified with ideologically. Areas of CBT that allow for this were strongly emphasised by counsellors, but the extent of the attachment to personal meaning, although still practiced, couldn't fully be expressed to others within the IAPT role.

Sub theme 3.1a–2: Treating clients as individuals

Related to this notion is the need to individualise and personalise treatment, extending from the humanist notion that each individual is unique and has potential (See Rogers 1957). CBT theory balances a tension between the need to formulate, constructing a personalised map of the client's problems and their maintenance processes, and diagnosis, categorising individuals according to a number of narrower conceptual frameworks and standardising treatment according to these frameworks rather than the individual. Counsellors clearly placed much more emphasis on individualisation than on conceptualisation:

> P5: "It's almost like I'd like to enter into their world and see their world from their perspective rather than just the symptoms and try to just fix the symptoms". (19-22)

As above (3.1a-1) the ideological attachment to treating people as individuals was partly realised within the IAPT role, and some counsellors re-scripted CBT to their model or emphasise aspect of CBT

confirming the individualised approach. This helped to reduce role conflict as former practice in this area was retained.

Sub Theme 3.1a-3: Client seen as a whole (not problem or symptom).

Although individualisation is important, it is also considered important to see the client as a whole, not just in the isolated context of their problems, and also experienced personally by the therapist, not just according to established concepts. This notion is less recognised within CBT, but was clearly both identified with and practiced by the counsellors in the sample, indeed until this was established, counsellors may not have felt safe to practice CBT:

> P5: "the very first session is important for me to get into the whole of the understanding as a person rather than symptom after that yes this become easier". (38-40)
>
> P3:" …it feels like the like the whole is more than some of the parts so if you do a five areas model it's almost like waters the…some kind of experience down than when I kind of formulate in that way I lose something". (50-52)

Like the other sub themes to 3.1a, aspects of CBT not consistent with this theme are resisted.

Sub Theme 3.1b: Client is Central – Counsellors personal motivations.

There was a strong rationale offered by the counsellors to retain the centrality of the client. However, there is a recognition that counsellors often enter the profession to fulfil their own needs (Wheeler 2007), and some personal motivations for retaining the centrality of the client at the expense of some CBT practices is explored below. The use of gut level skills may mask linear processing deficits (see 4.3.5):

P5: “It’s almost like I’d like to enter into their world and see their world from their perspective rather than just the symptoms and try to just fix the symptoms”.
I: “So that’s something that very much exists for you now”?
P5: “It does and it really touches me”. (21-24)

Sub Theme 3.1b-1: Self-esteem from using “gut level” skills

There appears also to be personal reasons for counsellors to emphasise the centrality of the client. The role of personal motivations for counselling and psychotherapy processes go back to Freud (1974). Great emphasis is placed in counselling on using intuition or “gut” responses, there is a possible tendency for counselling training to select for those (Mander 2004).

There is an additional reason why the counsellors wanted to rely on their gut rather than established protocols, and that is because it is more creative and stimulating. and counsellors appeared to obtain some personal esteem and motivation from doing this, performing a technique” lacks something” compared with instinctively being in tune with the client:

P2:”I think it would drive me out of my mind so I think maybe that creativity, that flexibility, maybe working at a different level sometimes in the room, the exploratory level, more artistically, more creatively I think maybe I still…possibly more advanced CBT therapists bringing as well…” 459-461

Sub Theme 3.1b-2: Fear of negative evaluation

There may also be a motivation to retain a centrality of the client due to a fear of negative evaluation from others. Where the client is central, responding to that according to your own experience is valid – there is no ‘wrong’ answer. Within CBT there are correct and incorrect interventions, and the possibility of being ‘wrong’ opens up the possibility of criticism from others – this seemed especially significant during training:

P4: “When I was worried about… is what I’m doing CBT and am I any good at it or actually I think I might be quite bad at it and when I was anxious about those things I think I wasn’t giving very good therapy”. (276, 277-8)

Fear of negative evaluation prevented full honesty within supervision about both feelings and practice, which served to maintain them within the liminal space.

Sub Theme 3.2: Being authentic and real

The other significant theme in the "retained" category is the need to be authentic and real, communicating their experience to the client and allowing the client to do the same. The use of concepts, protocols, compartmentalisation, and diagnosis were seen as watering down this process. 'Authentic and real' overlaps significantly with the core condition of genuineness. This concept also incorporates a willingness to acknowledge and explore ambiguities, even if they cannot be labelled. There is not an out-and-out commitment to this process all the time in CBT training as promoted in counselling, but was highly valued, and resisted when placed under threat, for example in supervision:

> P3: "Coming to supervision with a boiling down or a diluted down of something that feels significant, sometimes I don't even know what the words are but something's going on and I need the space in supervision to do that, to have that conversation with other people witnessing it" (227-230*)*

In some respects the genuineness was integrated into CBT, for example, CBT was delivered but without the "inauthentic" conceptual language.

> P4: "...or you could just be like a normal person and talking normal language and say how would you feel about us trying this work" (286-7)

A sub-feature of authenticity is that of permissibility to not fully understand a concept, or oneself. Self-doubt is encouraged within counselling, seen as an important vehicle to explore the unknown to make sense of experience. Counsellors viewed CBT as prematurely reducing experience to a

conceptual framework, which reduced the ability to ask legitimate questions of your experience which has the potential to promote further learning and reflection. Again, CBT is not against the notion of self-doubt, and readers may remember that "guided discovery" is a measure of therapy skill in CBT. However it is clear that counsellors had a stronger identification with self-doubt than CBT therapists, who balanced self-doubt with objectivity

> P4:" I was reading a BPS thing on Facebook yesterday about self-therapists self-doubt and that better therapy outcomes are associated with therapists who have experienced self-doubt…"
>
> P1: "…oh good" (generic laughter)
>
> I: "So how does that fit in with you as a group"?
>
> P2:" It was part of being with the client and bringing ourselves into that learning, it's that flexibility isn't it, what part do we play in the therapy"? (589-593, 604-605)

Although the core conditions and the therapeutic relationship were mentioned occasionally, it is perhaps surprising that it is only a relatively minor factor in on-going identification. Counsellors were clear that the need to respond flexibly to the client's needs may include empathy and unconditional positive regard, but it was the flexibility that is central, not the use of any single skill or technique. Counsellors stated that the flexibility may lead them to use an assertive, expert, or educational role if that was what is required by the client, confirming the above point.

Counsellors described retaining aspects of their practice, especially relating to a freedom to respond to the client, and being authentic. Counsellors described being forced to reject these principles during training in order to pass the training. While the process of training caused significant movements and concessions to CBT, aspects of the training also included performing for those observing, but not investing in certain principles. Practices from counselling that were briefly not practiced, but also not disinvested in eventually return for two reasons. The first of these is because because there are lower levels of governance over the therapists practice post training, and

secondly, as previously mentioned, CBT has become more permissive of more generic psychotherapy approaches as the evidence grows for their use, and the legitimacy of and evidence for more than one approach to the same problem.

> P5: "But for a while it felt like unlearning and relearning something new, but now over the years it just feels like personally I feel I've got to a comfortable space to pick up what I've learnt and bring it back into my practice because I feel there is has a value and a role in the work I do".
>
> I: "So it's something you almost kind of had to leave behind for a little while but you've kind of brought it back in"?
>
> P5: "It felt as though you have to perform you know".
>
> I: "You had to almost lose a part of yourself for a little while but now it's allowed back in again"? (overtalking)…
>
> P5: "…and then bring it back because it was…it's almost like ingrained and you're trying to go against the grain it felt hard, but you had to do this exam, it had to come across as though you're doing CBT but you can't change the leopards spots…" (Participants laugh)(610-617)

5.3.4: Theme 4 – Changed from counselling practice

Counsellors have described a strong initial resistance to CBT, and it has been noticed that in some areas they "played the role" during training but retained their counselling identity and practice, often in adapted form. This section focuses on areas of genuine change, where CBT principles have been adopted and counselling ideas and practice have been superseded by CBT. Within this theme there are seven sub-themes:

Sub Theme 4.1: Assessment and formulation

One of these areas is that of assessment and formulation. There is no single accepted way of assessing in counselling, other than responding to the client's needs, and possibly taking some

historical information. The lack of structure posed a dilemma for the counsellor, who wanted to encourage the client to experience and express their emotions, but also to contain them. The structure of CBT, although in many ways problematic ideologically for counsellors, was deemed to add value to the counselling practice because the counsellors' experience was that clients respond to the clarity of the formulation process, and this helped maintain a consistent and contained focus in therapy, and thereby better expressed outcomes for the client. As a result, Assessment and formulation according to CBT was broadly adopted.

> P2: "Yeah for me I think yeah, for me I suppose my assessments are sharper, more focused, (Yes's) it's given me skills and things whereas I suppose our training in counselling's has always been a little bit vague in that…" (303-305).

Sub Theme 4.2: Labelling, describing and conceptualising the ambiguous

The structure of CBT compared with a vagueness in counselling also adds value in other ways. For example, one counsellor states she was at times better able to label some of the processes occurring within the therapy, whereas before she would have experienced, but not have been able to label and conceptualise what is occurring. This improved the accuracy and clarity of the experience, which again met the counselling goal, but challenged the underlying ideology "client is central" revising it to "best service to the client is central"

> P3 "And I probably think I'm better at naming…like when you're working with someone who's really resistant or really kind of challenging in a particular way and as a counsellor you might really grapple with that but I think I'm quite a lot clearer now, that I'd actually say it seems like you're really ambivalent about changing or feels like actually you might wish to change but I just might be more forthright about naming that, in a kind way".
>
> P5: "I think CBT allows that sort of challenge doesn't it and focus and that's certainly given me that notion to do that as well and the language which I might not have used in the same way". (Yes's)(321-329)

Sub theme 4.3: Assertiveness with unsuitable clients

The ability to name and label enabled the counsellors to have better self-regulation in the context of the therapy. Counsellors felt better able to identify when therapy may not be appropriate, when structure or focus may have been lost or not benefitting the client. This is not only due to labelling and naming, but the fact that CBT, probably through an emphasis on reflective practice, was perceived to improve the counsellors ability to recognise when the therapy is unlikely to be effective. The principle of the client being central remains critical, and the labelling and ability to say no increases the effectiveness of the therapy as it does not waste the client's time if the therapy is unlikely to work, and added another tool to the therapist's toolbox.

> P3:" … I think I'm better equipped to recognise people that I shouldn't work with, presentations that I might be vaguely aware of but not really understood necessarily at a counselling intervention might not be helpful." 317-321

Sub theme 4.4: Scepticism redacted

Although the counsellors had a certain resistance to the positivist agenda of CBT, this resistance was actually only present when the agendas are deemed to conflict with other agendas (especially those described in theme 3) or when they were deemed to be watering down the client's experience. The pragmatic, behavioural, and experiential approach to clients in anxiety disorders in particular demonstrated a value in the approach to the counsellors without minimising or invalidating the client's experience:

> P4: "I think I've given up the fact that I was really sceptical about CBT and how really effective it is particularly for some of the anxieties, the phobia, standard phobia models, (Yes's) it's amazing the work to do with basic and graded exposure that it produces something really significant and you can talk about it for ages so it's almost like I'd given up that idea about just sitting there and talking about it and I got into the let's plan and do something and it makes all the difference". 330-335

Sub theme 4.5: Benefits of structured therapy

A rather unusual exchange compared being client led versus being goal led in therapy, the latter being broadly CBT based, and to a certain extent imposed on the therapy by IAPT service requirements. Counsellors to an extent saw being goal led as a positive, but only because it enabled the therapist to stay better and more effectively with the client's problems. This was acknowledged and used, but again as one of a number of strategies helping the counsellor respond to the centrality of the client's needs. In other words, a goal focus adds an extra dimension and becomes used as a tool to enable a greater client focus under some circumstances.

> P5: "Before it was client led now I think for me it's been more like goal led, you know outcome led and structure seems to be coming in a bit more. It's definitely creeping in".
>
> I: "Ok is that a general experience"?
>
> P4: "Yes I'd agree with that, it's like I've given my clients a wide birth but I can still kinda like pull them back in whereas maybe before…so I think it's given me that focus and that you know ok let's come back here". 309-12, 314-317

Sub theme 4.6: Creativity of behavioural therapy

The counsellors positive experience of CBT in that context appears to move the hostility and resistance to CBT, not only because it is congruent with their view that therapy should be emotion-focused, but also because it is congruent with their view of themselves as creative facilitators, as opposed to their initial view of CBT as mechanistically delivering a one dimensional set of protocols. Although the emotion focus is not new, CBT contributes a new idea that greater proactivity can lead to emotional experience, expression, and resolution.

> P1: "…so it's ok to very active isn't it but in counselling we may well have withdrawn from it that CBT can be active".

P5: “Go and feed the birds in the park, never mind talking about being frightened of the birds let’s go and be the birds and see what happens”.

P1: “There’s a certain creativity about that isn’t there”.

P5: “And that’s what I love about it”. (390-5)

There were aspects of genuine change from counselling as practiced previously, some of which hasdinvolved a rejection of previously held attitudes and practice, and some adoption of new ideas which have been added to existing attitudes and practice.

P4: “I think it’s a model that works for my client and I’m quite comfortable”. (166-167)

Sub Theme 4.7: Shift in epicentre of allegiance – CBT problems viewed from within

CBT was historically seen as “the establishment” by counsellors, and retaining an independence of practice from establishment frameworks, such as the medical model, was considered important for the counsellors, as we noted in 2.4.2. Earlier in this section, we noted that, in spite of some on-going conflicts with the service, there was an acknowledgement of these problems from within a CBT zeitgeist, and a desire to improve it which is unlikely to be present if identification was low. Many of the criticisms of the previously ascribed to CBT are now targeted not at CBT itself, but at the IAPT version of CBT or the IAPT service model. In the example below, the counsellor described the problem of enforced role adherence as due to a service model enforcing a limited version of CBT, and not ascribing it to CBT itself:

P4: “Yes as we said before we started I’ve got to be very careful that my identity…that I’m talking about IAPT in a way as opposed to CBT because that’s the only thing I’ve known, CBT I’m sure it’s richer, I’m sure it’s more creative and it’s more…”

P2: “…what CBT is”?

> P4: “Yeah I’m sure CBT is like that, however in IAPT I always got that, how will I present this in supervision, how will I present as a case discussion, what is it that I’m doing with people, am I actually following my role...”
>
> P2:” CBT particularly has been quite a challenge within the IAPT service”. 100-101

There are examples of change that occurred but remains dissonant, uncomfortable, or embarrassing. We noted earlier that jobs that incorporate more than one role or identity do not necessarily resolve themselves. For example, counsellors clearly practiced basic formulation skills (5 areas), but they felt embarrassed about content and delivery:

> P3: “...if you do a five areas model it’s almost like waters the…some kind of experience down than when I kind of formulate in that way I lose something”.50-52

5.3.5: Theme 5 - Resisted

The three CBT’s

The theme of “resisted” (with five sub-themes) describes and analyses features of CBT practice which are not adopted once counsellors are trained and practicing CBT therapists. An immediate problem is encountered in this category when attempts are made to define CBT. There appeared to be at least three relevant ways of CBT being conceptualised by counsellors and / or understood by the reader. The first of these was an “anti CBT” projection of CBT by some counsellors prior to and during the initial stages of training. There were strong experiences of CBT competing with and superseding counselling in many NHS services, leading to understandable resentment from counsellors. The projection of CBT as “concrete, not valuing the therapeutic relationship, mechanistic, shallow”, etc. was generated by the counsellors to exaggerate real differences between the professions to market counselling, and this process in professional groups is discussed in chapter 2.

> P4: “I feel so much is lost from you know what’s been presented of if you’re just doing let’s just look at this one cognition, let’s just work with that, don’t talk about anything else...”74-76

The second definition of CBT was CBT as it is traditionally viewed (e.g. see BABCP 2017) and also as experienced by counsellors during training once initial prejudices have been overcome. There is a partial overlap with counselling in terms of a number of generic therapeutic skills, but also real differences in terms of evidence-based models, and treatment according to diagnosis, a correct way to treat a problem, etc. These differences, also overlapping with the first definition, are repeatedly conceptualised as “pure CBT” by the counsellors, and continued to be rejected in practice. This is a slightly narrow version of CBT as it is significantly constrained by the IAPT service model. There is an acceptance, however, of “CBT as currently practiced”. There was a recognition by the group that CBT in an IAPT context may not be “pure CBT” but it was still restrictive as the simpler nature of the client presentation leads to more homogenised and from the counsellors perspective more mechanised, practice. Counsellors identified with CBT as clinicians but not “IAPT CBT” from a more political perspective. There were some attempts to separate IAPT CBT from the third definition “broad church” CBT, e.g.

> P4: ”I’ve got to be very careful about my identity… that I’m not talking about IAPT in a way as opposed to CBT because that’s the only thing I’ve known. CBT I’m sure it’s richer, I’m sure it’s more creative…” (85-87)

A third definition of CBT is the version which is practiced by generic CBT therapists, and is increasingly widely practiced in the NHS, especially in IAPT. There was an acknowledgement from counsellors that this is changing:

> P1: “Beck actually said didn’t he in his recent article, he wrote an article didn’t he and he said it’s one of his regrets that it was so prescriptive at the start and he said actually he’s really, really happy that mindfulness ACT and those are coming in and over the years that’s what he’s learnt as well”. 507-510

Since the counsellors qualified there has been a widening of the remit of CBT to incorporate new evidence. This shift has largely incorporated practice ideas with which counsellors would sympathise. There has been a movement away from a single treatment strategy being the only approach to certain problems, there has been much more emphasis on changing process of thinking as well as content, and also emphasis on compassion and acceptance as valid therapeutic interventions. This appears to provide the therapist with a wider pick list of ways to approach the therapy and integrate it with personal values. It also reduces homogeneity and enables therapists to pick, in effect a "wing" of a broad church. Although "pure" CBT is still present in the third definition, it appeared to be less important as it is part of a broader range of approaches, and adherence is less imposed.

> P3: "I think still compassion yeah and that's why I think I find the third wave [of CBT] quite attractive, the compassion with the client and really sort of being present with them I think, I think that feels really quite important. 252-254

"Pure CBT" makes up a number of components, all of which were related to a positivist ideology, consistent with the evidence based approach, and also reflective of the fact that early proponents were medical practitioners and / or researchers. An evidence-based approach and a structured, positivist ideology are examples of features that cognitive and behavioural therapy initially had in common.

> P5:"I don't see myself as purist if you know what I mean, not very purist with the structure". 144-145

The areas of CBT not adopted by the counsellors are summarised below as sub themes:

Sub-theme 5.1: Reductionist thinking

Counsellors had a degree of resistance to reductionist thinking. Counsellors perceived aspects of CBT as over-conceptualising, indeed, weakening, a real human experience by formally labelling it. There was also, as noted earlier, a resistance to a linear approach to reasoning, and an implied assumption of "one size fits all", i.e. that there is only one correct answer for all people at all times in all contexts. The attitude towards reductionist thinking from counselling appears to have strong emotional reactions (aversion, disgust)

> P1: "when I felt it was prescriptive it didn't feel helpful anymore because it's like oh god I've got to work like this". 218-219

Sub-Theme 5.2: Practice protocols and "evidence"

Related to this is the notion of protocols and evidence. As mentioned above protocols and evidence also restricted practice, in particular in the context of enabling a flexible response to the client. Counsellors are trained to look for diversity and uniqueness in their clients, and as a result there is probably a stronger noticing of diverse factors not fitting into models and protocols. This did not mean an outright rejection of evidence based practice, but there was a resistance to only accepting one approach to evidence as evidence. There were a number of rather disparaging accounts of manualised delivery of purist approaches, for example:

> P5: "There's a book, there's the workbook, just go and do it, there's no room, no space for individuality".
>
> P4: "Why can't that be CCBT* put the words in the box, challenge their thoughts, and just go"?
>
> P1: " Yeah Yeah". (All in sarcastic tone) 477-9, 481-3

*Computerised CBT

Counsellors retained broader definitions of evidence, including Rogers' view of evidence as what is experienced through the senses. This enabled counsellors to reject some aspects of evidence-based practice not congruent with their experience.

Sub-theme 5.3: Diagnosis and symptom focus

Protocols are developed and evidence collected from a diagnostic perspective. Medicine had a significant influence in the development of evidence as already mentioned, particularly in that CBT interventions are based on the system of diagnostic classification. Diagnosis is based on current, observable symptoms, which are then "treated." The emphasis on reducing symptoms is problematic for counsellors as this approach may be experienced as superficial – other factors may be driving these symptoms. Counselling conflicts with medical ideology were noted in chapter 3.

> P1: "…I was just going to say does the person become a symptom (generic yeah's) and actually that isn't…certainly how I want to work and so it is taking into account things like context isn't it, the bigger picture, the emotions." 79-81

In practice CBT assessments look for a diagnosis and then would undertake a formulation looking at an individualised understanding of the maintenance of the problem, although this would usually be present focused. Counsellors acknowledged this, but struggled with narrow symptom focus and present focus within CBT:

Sub-theme 5.4: Expert role in therapy

One significant example of the expert role is that medicine and quantitative research is based on the notion of "practitioner as expert". As mentioned before counsellors struggled to see themselves in a superior role, and aspects of "pure CBT", at times, promotes the clinician to the role of expert. Without the notion of expert, establishing fidelity to the evidence base can be difficult at times. In

practice, CBT practitioners balance a facilitative / equal partner's role in therapy, and an expert one. Counsellors did not appear to struggle with the idea of an equal partner's role, even though the idea is new, but struggled to accept and absorb the expert role:

> P5: "actually I struggle with those things within offering CBT because there's a sense that I have to be the expert and actually that's (laughs)…doesn't sit very well… "263-5

Dropping the expert role actually appeared to assist the counsellor-CBT therapist to identify with CBT more, as it makes the therapy, in their view, more workable for therapist and client. This participant noted that when she gave up trying to be the expert having being pressured to do so in training, she became much less anxious in sessions, and CBT seemed more workable:

> P4: "I'm actually quite a lot more relaxed using CBT in a much less self-conscious way because…and I suppose I'm thinking about what you said about being an expert and of course you can put your glasses on and get your clipboard and go well PTSD and how we CBT therapists treat that is [sarcastic tone]…or you could just be like a normal person and talking normal language and say how would you feel about us trying this work, it's just using ordinary words isn't it to not make it really academic or not make it at one end of the spectrum as a very specific treatment that's got very specific language. But for me…I can only speak for me, I have to not be anxious and be normal about that stuff". 283-290

Sub-theme 5: Academic culture and language.

Counsellors perceived a broader culture of expertise within CBT as difficult. CBT compared with counselling is a more "academic" profession, with research validating conceptual ideas which are then filtered down into practice. By comparison, counselling is more reliant on the skills of the individual on validating ideas related to the experience of the client. There was an on-going disparaging rejection of the "CBT expert elite" and also to the academic language they create. Research assumes a single truth, superiority of some forms of evidence over others, etc., and this was unpalatable to the counsellors, and enabled them to not adopt some evidence based practice.

P1: "...some of the CBT theorists it strikes me have quite an arrogant attitude and I think that idea of this is the way to do it, this is the only way to do it which then the department of health brought into as well so I think we were set up in a particular way". 294-6

P1: "The research...is about massaging the so called experts' egos". 577, 578-9

5.4: Summary of counsellors' practice of CBT

Counsellors described a difficult transition process, incorporating active resistance to being forced to drop counselling practices in training, triangulating the data from part 2 of the research (See Figure 6.2). Some permanent change occurs from forced exposure to CBT through disconfirmation of expectations and dissonance, and these are explored in chapter 6. Some practice change relapses at the end of learning when practice is less enforced, also in this period, CBT is more liberal in permitting some practices valued from counselling. There was a strong resistance to some aspects of CBT that do not overlap with the counselling agenda, such as the positivist and reductionist ideology, which is becoming less important over time. The aspects of practice that were retained from counselling was the client focus, and the need for creativity and value in their work. Where CBT was able to work within this context, change occurred and was retained. However, it is clear that counsellors did not achieve a full transition to an archetypal CBT practitioner, according to the evidence base of practice. This will be explored further in the following chapter.

5.5: Discussion of phase 3 of the research

The process of comparing nursing and counselling approaches to CBT post-qualification are difficult as different issues are raised by each profession. However, themes that are comparable are outlined in Table 5.4:

Table 5.1: Comparison of CBT practice between mental health nurses and counsellors

Factor	Nursing	Counselling
Identification with CBT	Complete, aspirational.	Identification with CBT generally Rejection of some aspects Desire to change CBT from within
Attitude towards previous practice	Shame and embarrassment	Nostalgia, ideal.
Relationship between core profession and CBT	Resolved	Some on-going conflict. Liminal Space.
Form of CBT Practice	CBT, With aspects of nursing Where conflict exists, CBT always preferred to nursing	Some aspects adopted, some resisted, some aspects of counselling retained. Some attempts to re-script counselling as CBT Uncertain outcome where CBT and counselling conflict,

The findings revealed two significantly different processes of reconciliation of core professional roles with CBT. Mental health nurses invested in moving “up” into CBT, leaving almost all aspects of nursing that could conflict with CBT behind, but “added to” CBT practice where there was no conflict, particularly to facilitate adapting the role to the broader context of the British National Health Service. Many of these aspects remain not taught on high intensity training programmes, and it is clear that parity between core professions should not be assumed post training. Whether

teaching these wider remits of the role adds value or dilutes clinical practice will be discussed in the following chapter.

By contrast, counsellors adopted a different approach to CBT practice. Although there was an allegiance to CBT in general terms, and an adoption of many CBT principles, the practice of the counselling group very clearly excluded certain aspects of CBT. In particular, there was an avoidance of adherence to more positivist aspects, including strict use of models and adherence to the evidence base. While this may invalidate the evidence base, it is not clear whether this practice affects outcomes.

There are also differences in application of CBT. Counsellors adopted the ideas and principles of CBT but retained the right to deviate from protocols when this fitted with their instinct or the client's needs. The right to be autonomous, using CBT within a broader therapeutic context, was considered more important than adherence to models. Nursing, by contrast, applied CBT principles more literally. While there was some reflection and changing practice as a result (practice based evidence), this was a considerably more concrete process of application compared with counsellors.

Mental health nurses appeared to have resolved their identity conflict, but counsellors appeared to fall into an on-going liminal space where they acted as if they are fully CBT in orientation to their managers and sometimes supervisors and peers, but in practice they rejected aspects of CBT ideology and practice. Nurses, being broadly adherent with CBT, adapted to changes in evidence reasonably well. Currently, the direction of CBT generally favours use of broader therapy skills favoured by former counsellors, although therapeutic trends and evidence are prone to change.

Chapter 6: Discussion

Chapter 6: Discussion

This chapter seeks to offer both triangulation and a chronological context to the three phases of the research, then summarise its findings, and offer recommendation and directions for future research.

This thesis has presented research relating to the core professional group's contribution to the IAPT High intensity role three distinct Phases. Phase one of the research had the overall aim of "Assessment of core professional skills in entering IAPT (CBT) training". The research clearly demonstrated that significant differences in skills levels (Objective 1a) and reflective abilities (Objectives 1b and 1c) existed between the core professions, challenging the notion that the 3 year "core profession or equivalent" qualification for IAPT High Intensity training is not equivalent between the core professions. Differences in skill levels occurred across almost all domains, with perhaps an unexpected finding that the non-professionalised "KSA" group frequently outperformed their professional colleagues, challenging the notion that professions add value (e.g. NMC 2017). Accuracy in self-assessment was generally similar between the groups for CBT skills (i.e. that they hadn't yet been taught), but varied considerably between the groups for generic CBT skills that students would be expected to know, with KSA typically outperforming nursing and counselling. This suggests that having a profession leads to an over-confidence in clinical skills where those skills are identified with or idealised by the profession.

Phase 2 of the research had the aim of understanding the process in becoming a CBT therapist, with the objective of developing a theoretical understanding of how each profession learns and transitions to CBT. To achieve this, a model of transition for each of the core professions has been identified. These models identified different learning processes in CBT for each core profession, often being filtered through a professional lens (e.g. self-practice). Expectations, existing professional practice, and changing professional coping strategies all inhibited learning, especially for the core professions. The role of grieving and loss of role is also significant for counsellors.

Although the KSA group experienced the same difficulties on the course, a lack of inhibiting factors including openness to experience, objective and unbiased reflection and coping, and self-protection from negativity, all contribute to a smoother and relatively complete transition.

Phase 3 of the research had the aim of providing a descriptive analysis of the practice of CBT in each core profession, with the objective of establishing how each core professional grouping practices CBT post training. This was achieved by conducting a semi-structured interview for each core profession, and developing themes through thematic analysis, with three themes for mental health nurses and five for counsellors. Results of the research noted a "CBT plus" approach to CBT by the nurses post qualification, bringing in a number of factors from nursing perceived to augment, but not conflict with CBT. Counsellors, by contrast, retain some aspects of counselling, or try to re-script them as CBT, while rejecting some aspects of CBT and retain some aspects of counselling. They remain in on-going conflict between the roles and this does not resolve.

Direct comparisons between the core professions, especially in phases 2 and 3 of the research, are limited since, because the methodology of the research prevented leading the research down pre-defined paths, different themes have emerged, and even where comparisons are possible, adopting a comparison would not be indicative of the relative importance or richness of the theme. To this end, the researcher has decided to compare each core profession across the timeline of before, during and after IAPT training, triangulating findings where appropriate to consolidate and reinforce the quality of the findings.

There are a number of limitations to this research. The sample size was small across all three phases, so full generalisability still needs to be established through replication. Likewise, phases 1 and 2 used only one training institution. Although phase 3's participants had trained in four different institutions, they worked for the same organisation, also limiting generalisability.

It was also not possible to research all professions at all times due to small sample sizes. Social workers and psychologists were not researched as a result and occupational therapists were only included in phase one of the research. The number of participants used in the study only just exceeded the numbers consenting, so stratification for factors such as age and gender was not possible. The KSA group did not have a large enough sample size to participate in phase 3 of the research, but this was not necessary because a complete transition occurred with this group in phase 2.

The strengths of this research include that it clearly identifies skills deficits (Phase 1) and problems in transition (Phase 2) for each core profession. Addressing these difficulties by supporting core professions in changing their coping strategies, managing loss, early enforced practice and acknowledgement of existing frameworks, would suggest a likelihood of a smoother transition. This research challenges the foundation of research in CBT, i.e. homogenous practice.

A further strength of this research is that that triangulation of the data and methods of the research have occurred consistently, and this has allowed the strengths of one method to outweigh the weaknesses of another, meaning that data, particularly related to phases 1 and 2, can be corroborated by approaching them in different ways. Triangulation approaches completeness in the collection and analysis of data (Jack and Raturi 2006). The aims have been achieved in different time periods, using different source material, different methods of analysis, and different influencing factors influencing responses (E.g. individual versus group). Examples of this triangulation are evident throughout the conclusions for each core profession.

6.1: Conclusions – nursing.

The mental health nurses' contribution to the IAPT High Intensity role is summarised in Figure 6.1. A lack of skills across a range of CBT areas, with the exception of the more didactic and procedural skills, when compared to other therapists observed formally in phase 1, confirming nursing as practiced according to the research (e.g. Cleary 2004). This is confirmed by comments in phases 2 and 3 describing no opportunity to practice therapeutic interventions in the nursing role due to a number of factors, a didactic, emotion-suppressed way of working, in the context of an expert role and no framework for reflection (Bray 1999). There is some knowledge of the educational and procedural aspects of CBT, and any interventions are delivered through this lens. Some mental health nurses in part 2 confirm the assumption they made at the time that they already knew CBT and this explains an over-confidence in their clinical self-ratings in part 1 of the research, both compared with their supervisor and compared with other professionals. Retrospectively, in part 3, mental health nurses describe embarrassment at their former practice.

Throughout part 2 and 3 of the research, mental health nurses view CBT as aspirational, not just in terms of career progression, but also in terms of practicing therapeutically according to the idealised nursing model. Both nursing and counselling describe difficult transitions, a significant gap between the core profession and CBT, core professional attitudes interfering in learning processes, and some similar processes in resolution and transition. Mental health nurses, however, make a much more complete transition than counsellors, and the most significant difference between them is the aspirational "push" (Ellemers et al. 1990) towards CBT, and the lack of constraint of former values once the transition process begins.

Figure 6.1: Triangulation and summary of factors influencing mental health nurses' transition

	Pre-training / start of training	During Transition	Post Qualification
Phase 1	Over confident in generic skills Didactic and procedural skills only equivalent to others		
Phase 2	Over confident in generic and CBT skills Ready to leave the profession – no attachment Psychiatric model a heavy influence	Avoidance of evaluation, enforcement Struggle with formulation, reflection, emotion Withdrawal of professional distancing as coping Self-reflection and awareness through concrete nursing lens Support, Positive Role models, and client experiences	
Phase 3	Retrospectively ashamed of didactic / expert role /coping	Release from restrictive role Reflective skills evident	fairly complete transition Addition of nursing skills to CBT role.

During the transition, the self-care protective factor from the nursing role of emotional distancing and expert role is not allowed by CBT. Mental health nurses largely avoid this at first and in phases 2 and 3 nurses note that they intend to qualify without experiencing this lack of protection, and that they continue to be avoidant until they have no choice but to adopt a more open and reflective stance through a combination of role play, taped and assessed practice, and supervision pressure. The start of a reflective process occurs not through reflective learning itself, but as a result of external environmental pressure to change behaviours, seemingly through exposure and cognitive dissonance. Once self-practice and self-reflection starts, a positive maintenance cycle is quickly established, accelerated by a release from the restrictive nature of nursing and supervisor support (from phases 2 and 3) and positive client experience (from phase 2). The process of self-practice and self-reflection is rather mechanically applied compared with other groups (phase 2), and the general narrative of phase 3 is rather pragmatic, possibly suggesting that, in spite of very significant changes in self-awareness and a commitment to self-practice and self-reflection, there remains a somewhat positivist approach to the process of reflection and skills application, which may be retained from nursing.

For the most part, a relatively complete transition occurs (phases 2 and 3), although it is not complete at the end of training and this continues to occur afterwards, even in the context of reduced observed and supervised practice (phase 3). Areas of theory and practice where there is conflict, such as expert role / client responsibility, emotional experience and expression, risk formulation, and extended interventions / depth all resolve in favour of CBT (phase 3). All aspects of CBT are adopted, however the role is added to in the areas of medication (when asked), risk, and awareness of health service culture. Immediate responsiveness to the environment from nursing initially interferes with planning and reflection, however it is retained in the context of observational skills and continuing to be aware of their gut reaction, albeit in the context of improved self-awareness. Mental health nurses add that they believe that other professionals value their nursing background, especially in the context of referrals and interdisciplinary communication, implying that

their knowledge of working at the “coal face” of mental health care is respected and implies understanding of other professionals’ perspectives.

Implications for theory - nursing.

The traditional idea that professions or professionalism adds value (NMC 2017) does not appear to apply with mental health nurses in the context of transition. Adherence and attachment to mental health nurses’ professional values interfered with learning in the new profession of CBT in this study. Further investigation is required to clarify whether attachment to professionally marketed ideas interferes with objective observation and learning in other contexts. The process of professional adaptation appears to be that features of the old role that conflict with the new role (which is fully adopted) are no longer practiced

Nursing training has strived for a theoretical move away from psychiatry, however, research from all 3 parts of this thesis confirm a relatively strong practical influence from psychiatry and management, largely dictated by the service delivery model, and a relatively weak influence of the nursing model, in spite of ideological support. This research suggests the validity of theoretical perspectives such as that of Rolfe (1996), and also of research such as Gijbels (1995) and Ellsom et al. (2008) rather than literature designed to promote the profession (NMC 2017). Both individual and focus group methodology confirm similarities across secondary care working, regardless of whether the nurses worked in inpatient or outpatient settings. The continuing emphasis on the immediacy of relationships in IAPT, and the belief that they do this well corroborates Barratt's (1996) research suggesting this is a unique area of skill in nurses,

The model of Declarative-Procedural-Reflective (Chaddock et al. 2014) are confirmed as broadly accurate as a process of learning CBT, with an emphasis on Self-Practice and Self-Reflection (Bennett-Levy et al 2001) as a very significant learning factor throughout phase 2 of the research.

While mental health nurses eventually adopt the model, there are a number of areas, such as awareness of the self, and theory – practice links that are initially absent within the nursing students. Mental health nurses does not adopt the practice this practice spontaneously, partly due to existing nursing coping strategies of avoidance and emotional distancing. Behavioural change towards a more reflective approach needs to be enforced, in some examples through exposure and / or cognitive dissonance.

Implications for practice and recommendations - nursing

- Mental health nurses broadly practice CBT according to the evidence base, but clearly add to the role. It is not clear whether these additions to the role (discussing medication, risk assessment, etc.) strengthen or dilute the role and the consequent outcomes. Further research is needed to clarify this.
- The role of emotional distancing and professional expert appears to protect the nurse from emotional distress / burnout in their core profession, discussed in 4.2. Self-practice of CBT and self-awareness and reflection appear to serve a similar function within CBT. However, this is poorly recognised in the curriculum and it appears that nursing strategies are not permitted before self-practice is fully embedded. Implementing self-practice is a significant paradigm shift for nurses as the responsibility is shifted from the technique / profession at an unconscious level, to the clinician at a conscious level. A recommendation to include self-practice at a very early stage in the course (or in mental health nursing training), teach specifically about the impact of the core professions, and adopt a more structured approach (in both teaching and clinical supervision) to withdrawing the safety behaviours (from a CBT perspective) of professional distance.
- The separation between values and practice in nursing leads to an over-confidence in initial skills and a delayed and complicated transition compared with the KSA group. This makes the nursing workforce inflexible to transition outside of their professional role. A review of nursing

curriculum to increase congruence between ideals and practice may increase flexibility of the nursing workforce.

6.2: Conclusions - counselling.

In 2.4.2 it was noted that counselling is not principally an academic profession, and has a wide variety of practices, but with many themes in common. Results from phase 1a of the study indicate that counsellors have significantly higher levels of skill in three generic areas of CBT practice than mental health nurses (guided discovery, pacing and feedback) whereas mental health nurses (and also KSA and OT) score significantly higher in homework setting. Therefore the practice gap between counselling and CBT is no wider than the gap between nursing and CBT, and may be narrower. The practice gap therefore is not a primary reason for the difficult and incomplete transition. Counsellors had significantly lower levels of initial CBT skill than KSA practitioners in 7 domains even though initial skills are at least in theory comparable, suggesting that there may be a factor related to professionalism / previous ideology that interferes with skills practice. Part 1b confirms KSA are more accurate than counsellors in 4 domains, accounting for the majority of the difference between the professions, and also that counsellors skills are significantly different to their supervisors in 6 domains. It appears to be the case that counsellors expect themselves to be more competent in CBT skills than they are, and the gap is wider than perceived, and this is confirmed in Phase 3. Counsellors also describe losing some generic skills in the early stages of the course through lack of confidence (phase 2) and in the process of acquiring new skills. Ideological objections to CBT (Phase 2) and a coping style of amplifying emotional experience (Phase 2) are also absent from other professions.

At the start of the training, counsellors perceive themselves as competent, and expect to complete CBT training with their existing skills respected and validated. They hold a perspective that all therapies are fundamentally the same, with different emphases (phase 2), which is an ideological challenge to them. There is also an ideological belief about the right to respond to the client (Phases

2 and 3), and in phase 3 it was observed that this protects the therapist from negative evaluation of their therapy, which is prohibited early in the training, and appears to be a counselling profession specific strategy to manage burnout. We noted in chapter 5 that personal therapy and in some cases team support serve as additional protective mechanisms. A significant move is required towards personal responsibility within the area of protective strategies for counsellors, which appears to be difficult in the context of a shared ethos and fear of negative evaluation.

Phase 2 of the research conceptualised the transition process as a loss. This included a loss of identity, competence, purpose, philosophy, and coping strategies (Worden 2008). The counselling ideal is much more integrated with the person than nursing, which appears to be a factor in why it is experienced more deeply. The requirement to conform to CBT practice is conceptualised as humiliation and defeat by some counsellors, which amplifies the sense of loss. Avoidance, carrying on practicing counselling, and ideologically defending counselling occurs in training (Phase 2) and although the latter decreases, counselling practice re-emerges after training finishes (Phase 3), when therapeutic governance (regular recordings, frequency of supervision) lessens. Engaging with CBT is forced during training, and was note to be necessary to maintain the role (phase 2) and does not occur spontaneously through reflection. Once engaged, ideological discussions maintain the counselling perspective, but experiential learning revises perspectives. Counsellors make a significant but incomplete transition.

Figure 6.2: Triangulation and summary of factors influencing counselling transition

	Pre-training / start of training	During Transition	Post Qualification
Phase 1	Lower levels of skills than non-professionalised Less accurate in skills perception in some domains Superior generic skills than nurses in 2 domains		
Phase 2	Perceives self as competent Right to practice Autonomously "All therapies are the same" Avoidance , carrying on	Loss of ID, competence, purpose Political defence of previous role Realisation of transition gap induces crisis Humiliation and defeat Crisis amplified by emotional coping Self-practice emphasises experience as client Partial adaptation	
Phase 3 Transition	Assumed parity of psychotherapies Gap larger than expected	De-skilling and shame Mixed motives about transitioning Adaptation to Survive	Liminal space Identification as CBT Positivist "Pure" aspects of CBT rejected Blend of counselling, CBT, and the individual Autonomy and client focus preserved

The process of learning largely takes place through a counselling lens. The centrality of the clients as opposed to the therapy in CBT remains, and experiential learning occurs through the counsellor placing themselves in the role of the client, in some respects repeating the "personal therapy" role common in their training. The emphasis on experience of the therapy from within is an acceptable way of learning to the counsellors, compared with application of skills, the standard way adopted by the mental health nurses. It is not clear from the research whether this style of learning assists with or hinders learning and adoption of CBT practices, although the right of the therapist to remain clinically independent in therapy decision making also remains a lens through which CBT is learned, and is also influential.

One possible reason this lens is retained is because compartmentalising ideas and applying them homogenously tends to be a less common processing style amongst the group. More common is a wholist processing style, described in 4.3 (Phase 2). Counsellors do, however see some advantages to this style of processing, and they report that CBT improves the structure of assessments, labelling and naming concepts, and assists with assertiveness when necessary. These aspects of CBT are added to existing skills as they are seen to make the therapist more receptive to the client (i.e. the counselling lens) in addition to benefitting the client.

Counsellors are attracted to the more experiential aspects of CBT, feeling it broadly fits with the ideology of how they wish to practice psychotherapy (Phases 2 and 3),however they reject positivist aspects of CBT such as adherence to protocols / evidence, and academic aspects of the profession (Phases 2 and 3). Aspects of counselling are maintained, and CBT skills and techniques are applied according to a philosophy that remains significantly influenced by counselling. The final product is a synthesis of counselling, CBT and the individual (consistent with Wills' (2007) research) and is likely to be at variance with a more standard application and delivery of CBT. In spite of this, there is an identification with CBT, and some evidence of loyalty to it (Parts 2 and 3).

Implications for Theory - counselling

The emphasis on loss has not been widely discussed in the literature in the context of transitions. The literature from Adams et al (1976) has not been updated, other than Williams (2008), but appears to be out of fashion even though still relevant. The essence of loss in the context of role transitions offers a good fit to the experience of the counsellors, and a revised model has been proposed based on the data in part 2 of the research This research confirms that the principles of the above model remains valid as a process, but the application shows some variation. For example, processes of denial and the absorption and active experiencing of the crisis are unique to counsellors in this research.

It was noted in phase 2 of the research that protective strategies (avoiding negative evaluation, personal therapy, and peer support) are present for the majority of counsellors in the sample. The presence of these coping strategies are poorly acknowledged within the counselling literature. The transition between the protective strategies for counsellors involved the loss of the existing protective strategy (e.g. personal therapy) before prior to the CBT coping strategy (e.g. Self-practice) being established. This can potentially account for the extent of the crisis, and this is not present within existing models of transition

Counsellors identify with, but do not fully practice according to, CBT at the end of training and post qualification. They neither fully belong to either profession but are caught in an on-going role conflict. Croft, Currie and Lockett (2015b) describe “liminal space” between roles, when researching nurse managers, and this research is suggestive of the presence of this phenomenon.

Implications for practice and recommendations - counselling

It is clear from the research that inadequate attention is given within the training curriculum to assist the process of transition for counsellors. Particular areas of emphasis need to include:

- Managing loss. Even with a working knowledge of loss, the extent of the difference is not anticipated (Phases 2 and 3, confirmed by aspects of phase 1b). Amplification of emotion and avoidance of the new experience delays learning (Phase 2) and may influence incomplete learning (Phases 2 and 3).
- Transition between professional coping styles would benefit from greater emphasis in the curriculum. Support for a transition to personal responsibility for self-care in a CBT format would benefit from being more explicit at the start of training and being an explicit part of supervisory support.
- Mandatory experiential learning and self-learning needs to occur early in the course. Counsellors appear to learn best in this way and emphasis on CBT knowledge is not absorbed and delays learning. This also would assist with coaching in individual responsibility for self-care (above).
- The loss of a right to always practice “as the therapist sees fit” in CBT means at times there is sometimes a “correct way” to undertake therapy, and this opens the counsellor to potential judgement, which is experienced as difficult, and there is not always an outlet to address this. At least some clinical supervision should be individual or profession specific during the early stages of IAPT training for counsellors to allow Fear of Negative Evaluation to be explored safely and without shame.

Counsellors are not practicing post training according to the evidence base, which may invalidate CBT interventions, affect commissioning and funding, and ultimately client outcomes. Some degree of variation in practice is inevitable, but there is an explicit avoidance of homogeneity of practice by

counsellors. While their practice is not supported by the existing evidence, further research is required to assess whether their variance from the evidence base significantly affects outcomes.

6.3: Conclusions - KSA

The KSA group demonstrated the highest levels of clinical skills and reflective ability in spite of no core professional background. This was contrary to expectations, with an assumption that professionalism would add value to the clinician. In spite of exposure to identical stressors between the core professions, phase 2 of the research observed a number of characteristics that were distinctly different from the professionalised groups of nursing and counselling (See Figure 6.3), which appear to be influential in a broadly successful transition, which include.

- No pre-judged expectations of the core profession appears to lead to accurate perceptions initially. This narrows the transition gap by requiring less unlearning.
- A commitment to the process and a desire to prove oneself. Most of the KSA group describe a perfectionist schema which drives both of the above. This group see themselves as inexperienced compared to their professionalised colleagues and this also drives a desire to prove oneself.
- Positive demeanour, gratitude for support, and viewing adversity as opportunity are all present in contrast to nursing and counselling.

  The lack of preconceptions and pre-determined coping styles appears to affect the above, which has been noted to have a multiplier effect on both speed and extent of learning.
- An ability to screen out unnecessarily negative information. The majority of members protected themselves who unduly focused on the negative or unresolvable
- No loss of status or competence. Nursing and counselling participants describe the move from conscious competence to conscious incompetence painful and stressful.

- No “unlearning “of previous role, which slows down the transition.
- No pre-existing professional coping strategies. There appears to be an emphasis on individual responsibility for coping, congruent with CBT coping.
- Vigilant, not avoidant coping style. This accelerates the reflective process.

The transition was complete, and served effectively as a baseline for a successful transition, and it was complete at the end of part 2, no follow-up was required in part 3.

Implications for theory - KSA

The research challenges the traditional notion that professions “add value” outside of the immediate professional framework, and appears to be a hindrance to transition although further research with larger samples is necessary to confirm this.

Small scale quantitative research suggesting vigilant coping styles show greater treatment gains than avoidant coping is triangulated with qualitative research from phase 2, albeit from a non-clinical sample (Bogels and Mansell 2004), and the results indicate that these findings are also accurate in a small clinical sample.

Some of the processes described (Vigilant coping, gratitude, adversity as opportunity) lack detailed research in the transition literature, and may contribute towards future thinking in model development, and in factors likely to influence success in transition.

Implications for practice and recommendations – KSA

KSA students start with higher levels of skills, better reflection, and smoother transitions than their professional counterparts. With a future need for flexible roles within healthcare settings, healthcare professions may benefit from addressing areas of excessive professionalization within their curricula.

Figure 6.3 – Triangulation and summary of factors influencing KSA transition

	Pre-training / start of training	During transition
Phase 1	Superior to professionalised groups in the majority of skills	
	Accurate reflection compared with supervisors	
	More accurate reflection than professionalised groups in some generic domains.	
Phase 2	Least contaminated by previous experience	Fewer preconceptions narrows transition gap
	Accurate or under confident perceptions of skill	Adversity as opportunity. Deliberate strategy of positive attitude
		No alternative forms of emotional coping facilitate transition
		Vigilant coping
		Complete transition – Investment in CBT with ongoing flexibility and willingness to learn

6.4: Occupational therapy

The theoretical framework for Occupational Therapy, the model of human occupation (Kielhofner 2007) does not have the same acceptance in practice within existing healthcare structures compared with psychiatric and psychological models, and, being a smaller and more disparate profession, often have to "fit in" with dominant zeitgeists in clinical teams, especially nursing. While there is a theoretical identification with the model of human occupation, but the practice is less protected, with multidisciplinary working heavily emphasised.

Implications for theory and practice, and recommendations – Occupational Therapy

Occupational therapists represent a very small sample of phase 1 of the research, therefore conclusions are limited accordingly. The Occupational Therapists' initial level of skill and reflection in phase 1 clarifies an existing level of skill and reflective ability, where professionalism interferes with both of these factors in nursing and counselling, and also complicates the transition process. Therefore it appears neither to be a registration with a core profession nor identifying with its values that inhibits transition, but a commitment to the practice of the rituals and behaviours identified by the profession (professionalisation). Conceptualising a more clear definition of professional inhibiting transition merit further research as managing them has the potential to improve workforce flexibility by making role transitions less difficult.

6.5: Novel contribution to theory/practice

It is clear that core profession is a significant factor in determining levels of skills and reflective ability in some domains accounting for up to 30% of the variation in clinical skills at the start of the course (see Table 3.5).

Phase one of this research confirmed that those without a core profession generally outperformed the more professionalised groups in levels of core CBT skills, contradicting the professions' traditional view of themselves that they add value. In general, where trainees had identification with CBT skills through their core professions, they were less accurate in their self-rating of these skills, suggesting that core professional identity may interfere with accurate self-processing in this area.

Traditional transition models assume generalisability to a range of conditions, but this research revealed different transition processes partly based on previous learning and identification through core professions. Some factors known are believed to exacerbate transition difficulties (Worden 2008) and these factors are confirmed by this research. The role of transition between coping styles of stress management was particularly important for mental health nurses and counsellors, as the existing one needed to be sacrificed before the new strategy could be fully adopted. This was partly responsible for an emotional crisis in nurses and counsellors, which, while acknowledged in the general literature, has not been previously explained.

Openness to experience assists transition processes in the KSA group, and has an inhibiting effect in the nursing and counselling groups. This is suggested in models such as Ashforth (2000), this research confirms this as an important factor in the process of transition to CBT. Neither the nursing nor counselling groups practice CBT according to the traditional reading of the evidence base. This undermines adherence to this evidence base, although whether this affects outcomes is unclear as idiosyncratic clinical practice is poorly researched.

6.6: Implications for practice

In view of the fact that there are considerable variations across the core professions on CBT skills prior to training, transitional processes, and clinical practice post qualification:

- Professional bodies of the core professions need to avoid excessive professional identification in core training curricula, which appears difficult to "unlearn" later, thereby interfering with workforce flexibility and transition to the CBT role.
- IAPT training courses need to incorporate training in adjustment processes for core professions so that they can be aware of issues raised in this thesis, in order to facilitate transition processes. This could be incorporated into Self-Practice and Self-Reflection (SP-SR). Support from role models from matching core professions may facilitate transitional processes.
- Research in CBT outcome studies administered by one core profession assumes generalisability to other core professions. This thesis suggests that this assumption may have limitations, and researchers should attempt to control for this where possible.

6.7 Future research

The following future work is recommended:

1. Replication of this study across a wider range of institutions and core professions to enhance generalisability.
2. Research into profession specific teaching and supervision support during training, and outcomes of this adaptation.
3. The role of coping strategies in transition would benefit from research to confirm whether this finding is specific to CBT, or is generalisable to other work roles.

4. It is clear that neither mental health nurses nor counsellors practice CBT classically according to the evidence base. Further research is required to establish whether this affects outcomes.

6.8: Conclusions

In conclusion, this study has provided original contributions to understanding the effect of the core professions on the IAPT High Intensity role. The approach fills a significant gap in the literature, which has previously only focused on learning and transitioning to CBT at the level of the individual (Chaddock et al. 2014). The research largely corroborates existing theory on transition, which has been synthesised within the literature review due to it being addressed from different perspectives. The majority of major findings have been present and triangulated across different phases of the research. The research establishes some guiding ideas for improving transition within the training curriculum for each core profession, which is likely to have a significant clinical impact, and this merits future research. The foundation of CBT, trials based on replicable practice, is challenged by this research, although it is not clear whether replicable practice is necessarily compromises outcomes or not, which merits future research.

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Appendices

Appendix 1: Part of the search strategy for transition between job roles

Strategy 113205 # Database Search term Results 1 Medline (Transition).ti,ab 232341 2 Medline exp "DISCIPLINES AND OCCUPATIONS"/ 10526201 3 Medline (1 AND 2) 73255 4 Medline (psychological).ti,ab 162506 5 Medline (3 AND 4) 957 6 Medline exp "HEALTH PERSONNEL"/ 371080 7 Medline (1 AND 6) 2451 8 Medline (4 AND 7) 65 9 Medline 8 61 10 0 11 Medline (role transition).ti,ab 32515 12 Medline (job change).ti,ab 2540 13 Medline (11 OR 12) 35049 14 Medline (6 AND 13) 1104 15 Medline 14 1058 16 Medline (4 AND 14) 57 17 CINAHL (role transition).ti 128 18 CINAHL 17 125 19 PsycINFO ("occupational adjustment").ti,ab 180 20 PsycINFO ("role transition").ti 51 21 PsycINFO ("role change").ti 57 22 PsycINFO ("job change").ti 50 23 PsycINFO (psychological).ti 66799 HDAS Export Search Strategy Role transition 10 Jan 17 - 15:16 Page 15 of 16 24 PsycINFO (19 OR 20 OR 21 OR 22) 338 25 PsycINFO (23 AND 24) 12 26 PsycINFO "ROLE TAKING"/ 2105 27 PsycINFO (23 AND 26) 26 28 PsycINFO ("work role transitions").ti 9 29 PsycINFO ("role transition from staff nurse to clinical nurse specialist").ti 0 30 AMED, BNI, CINAHL, EMBASE, HBE, HMIC, Medline, PsycINFO, PubMed ("broken two way windows").ti 0 31 PsycINFO (identity transition).ti 169 32 PsycINFO exp "PROFESSIONAL PERSONNEL"/ 272717 33 PsycINFO (31 AND 32) 8 34 PsycINFO (identity transition).ti,ab 2098 35 PsycINFO (32 AND 34) 172

Appendix 2– Outcomes for incomplete adaptation (Seelye and Waselewski 1979)

Non-acceptance – Transitioners carry on behaving as before
Substitution – Responses of new group / culture are learned and replace previous behaviours with this response
Addition – Transitioners accumulate new knowledge and make a judgement about which responses they use according to the situation and personal preferences.
Synthesis – Different elements of response patterns are merged.
Resynthesis – Different elements of both groups are merged in an original way not found in either culture.

Appendix 3 – CTS-r descriptors

ITEM 1 - AGENDA SETTING & ADHERENCE
Key features: To address adequately topics that have been agreed and set in an appropriate way. This involves the setting of discrete and realistic targets collaboratively... The format for setting the agenda may vary according to the stage of therapy - see manual.

Three features need to be considered when scoring this item: (i) presence/absence of an agenda which is explicit, agreed and prioritised, and feasible in the time available; (ii) appropriateness of the contents of the agenda (to stage of therapy, current concerns etc.), a standing item being a review of the homework set previously; (iii) appropriate adherence to the agenda.

ITEM 2 - FEEDBACK
Key features: The patient's and therapist's understanding of key issues should be helped through the use of two-way feedback: The two major forms of feeding back information are through general summary and chunking of important units of information. The use of appropriate feedback helps both the therapist to understand the patient's situation, and the patient to synthesise material enabling him/her to gain major insight and make therapeutic shifts. It also helps to keep the patient focused.

Three features need to be considered when scoring this item: (i) presence and frequency, or absence, of feedback. Feedback should be given/elicited throughout the therapy - with major summaries both at the beginning (review of week) and end (session summary), while topic reviews (i.e. chunking) should occur throughout the session; (ii) appropriateness of the contents of the feedback; (iii) manner of its delivery and elicitation (NB: can be written).

ITEM 3 - COLLABORATION
Key features: The patient should be encouraged to be active in the session. There must be clear evidence of productive teamwork, with the therapist skilfully encouraging the patient to participate fully (e.g. through questioning techniques, shared problem solving and decision making) and take responsibility. However, the therapist must not allow the patient to ramble in an unstructured way.

Three features need to be considered: the therapist style should encourage effective teamwork through his/her use of: (i) verbal skills (e.g. non-hectoring); (ii) non-verbal skills (e.g. attention and use of joint activities); (iii) sharing of written summaries.

NB: Questioning is a central feature with regard to this item, but questions designed to facilitate reflections and self-discovery should be scored under Item 9 (Guided Discovery)

ITEM 4 - PACING AND EFFICIENT USE OF TIME
Key features: The session should be well 'time managed' in relation to the agenda, with the session flowing smoothly through discrete start, middle, and concluding phases. The work must be paced well in relation to the patient's needs, and while important issues need to be followed, unproductive digressions should be dealt with smoothly. The session should not go over time, without good reason.

Three features need to be considered: (i) the degree to which the session flows smoothly through the discrete phases; (ii) the appropriateness of the pacing throughout the session; (iii) the degree of fit to the learning speed of the patient.

ITEM 5 - INTERPERSONAL EFFECTIVENESS

Key features: The patient is put at ease by the therapist's verbal and non-verbal (e.g. listening skills) behaviour. The patient should feel that the core conditions (i.e. warmth, genuineness, empathy and understanding) are present. However, it is important to keep professional boundaries. In situations where the therapist is extremely interpersonally effective, he/she is creative, insightful and inspirational.
Three features need to be considered: (i) empathy - the therapist is able to understand and enter the patient's feelings imaginatively and uses this understanding to promote change; (ii) genuineness - the therapist has established a trusting working relationship; (iii) warmth - the patient seems to feel liked and accepted by the therapist.

ITEM 6 — ELICITING OF APPROPRIATE EMOTIONAL EXPRESSION

Key features: The therapist facilitates the processing of appropriate levels of emotion by the patient. Emotional levels that are too high or too low are likely to interfere with therapy. The therapist must also be able to deal effectively with emotional issues which interfere with effective change (e.g. hostility, anxiety, excessive anger). Effective facilitation will enable the patient to access and express his/her emotions in a way that facilitates change.

Three features have to be considered: (i) facilitation of access to a range of emotions; (ii) appropriate use and containment of emotional expression; (iii) facilitation of emotional expression; encouraging appropriate access and differentiation of emotions.

ITEM.7 - ELICITING KEY COGNITIONS

Key features: To help the patient gain access to his/her cognitions (thoughts, assumptions and beliefs) and to understand the relationship between these and their distressing emotions. This can be done through the use of questioning, diaries and monitoring procedures.

Three features need to be considered: (i) eliciting cognitions that are associated with distressing emotions (i.e. selecting key cognitions or hot thoughts); (ii) the skilfulness and breadth of the methods used (i.e. Socratic questioning; appropriate monitoring, downward arrowing, imagery, role-plays, etc.); (iii) choosing the appropriate level of work for the stage of therapy (i.e. automatic thoughts, assumptions, or core beliefs).

NB: This item is concerned with the general work done with eliciting cognitions. If any specific cognitive or behavioural change methods are used, they should be scored under item 11 (change methods).

ITEM 8 - ELICITING AND PLANNING BEHAVIOURS

Key features: To help the patient gain insight into the effect of his/her behaviours with respect to the problems. This can be done through the use of questioning; diaries and monitoring procedures. The therapist works with the patient to plan strategies either to overcome or disrupt dysfunctional behavioural patterns.

Two features need to be considered: (i) eliciting behaviours and plans that are associated with distressing emotions; (ii) the skilfulness and breadth of the methods used (i.e. Socratic questioning; appropriate monitoring, downward arrowing, imagery, role-plays, etc.);

NB: This item is concerned with the general work done with eliciting behaviours and plans. If any specific cognitive or behavioural change methods are used, they should be scored under item 1 1 (change methods).

ITEM 9 - GUIDED DISCOVERY

Key features: The patient should be helped -to -develop hypotheses regarding his/her current situation and to generate potential solutions' for him/herself. The patient is helped to develop a range of perspectives regarding his/her experience. Effective guided discovery will create doubt where previously there was certainty, thus providing the opportunity for re-evaluation and new learning to occur.

Two elements need to be considered: (i) the style of the therapist - this should be open and inquisitive; (ii) the effective use of questioning techniques (e.g. Socratic questions) should encourage the patient to discover useful information that can be used to help him/her to gain a better level of understanding.

ITEM 10 - CONCEPTUAL INTEGRATION

Key features: The patient should be helped to gain an appreciation of the history, triggers and maintaining features of his/her problem in order to bring about change in the present and future. The therapist should help the patient to gain an understanding of how his/her perceptions and interpretations, beliefs, attitudes and rules relate to his/her problem. A good conceptualisation will examine previous cognitions and coping strategies as well as current ones. This theory-based understanding should be well integrated and used to guide the therapy forward.

Two features need to be considered: (i) the presence/absence of an appropriate conceptualisation which is in line with goals of therapy; (ii) the manner in which the conceptualisation is used (e.g. used as the platform for interventions, homework etc.). NB: This item is to do with therapeutic integration (using theory to link present, past and future). If the therapist deals specifically with cognitions and emotions, this should be scored under Items 6 (Facilitation of Emotional Expression) and 7 (Eliciting Key of Cognitions).

ITEM 11- APPLICATION OF CHANGE METHODS

Key features: Therapist skilfully uses, and helps the patient to use, appropriate cognitive and behavioural techniques in line with the formulation. The therapist helps the patient devise appropriate cognitive methods to evaluate the key cognitions associated with distressing emotions, leading to major new perspectives and shifts in emotions. The therapist also helps the patient to apply behavioural techniques in line with the formulation. The therapist helps the patient to identify potential difficulties and think through the cognitive rationales for performing the tasks. The methods provide useful ways for the patient to test-out cognitions practically and gain experience in dealing with high levels of emotion. The methods also allow the therapist to obtain feedback regarding the patient's level of understanding of prospective practical assignments (i.e. by the patient performing the task in- session).

Three features need to be considered: (i) the appropriateness and range of both cognitive methods (e.g. cognitive change diaries, continua, distancing, responsibility charts, evaluating alternatives, examining pros and cons, determining meanings, imagery restructuring, etc.) and behavioural methods (e.g. behavioural diaries, behavioural tests, role play, graded task assignments, response

prevention, reinforcement of patient's work, modelling, applied relaxation, controlled breathing, etc.); (ii) the skill in the application of the methods - however, skills such as feedback, interpersonal effectiveness, etc. should be rated separately under their appropriate items; (iii) the suitability of the methods for the needs of the patient (i.e. neither too difficult nor complex). NB: This item is not concerned with accessing or identifying thoughts, rather with their re-evaluation.

ITEM 12 - HOMEWORK SETTING

Key features: This aspect concerns the setting of an appropriate homework task, one with clear and precise goals. The aims should be to negotiate an appropriate task for the stage of therapy in line with the conceptualisation; to ensure the patient understands the rationale for undertaking the task; to test out ideas, try new experiences, predict and deal with potential obstacles, and experiment with new ways of responding.

There are three aspects to this item: (i) presence/absence of a homework task in which clear and precise goals have been set; (ii) the task should be derived from material discussed in the session, such that there is a clear understanding of what will, be learnt from performing the task; (iii) the homework task should be set jointly, and sufficient time should be allowed for it to be explained clearly (i.e. explain, discuss relevance, predict obstacles, etc.

Appendix 4: Supervision governance – validity of supervisor's scores

In order to maintain fidelity in CTS-r ratings between the supervisors, joint marking of tapes occurred between them on regular occasions. Four examples are included (one per page, with the month and year in the top left corner). The Y axis refers to the initials of the markers

10/09 "J"	KS	JH	RL	PB	RA
Agenda	2	2	2.5	2.5	2
Feedback	2.5	3	2.5	2.5	3
Collaboration	3	3	3	3	3
Pacing	3	3	3	3	3
I P Effectiveness	3.5	3	3	3	3
Emotions	2.5	2.5	2.5	3	2.5
Cognitions	2.5	3	2.5	2.5	3
Behaviours	3	3	3	3	3
G Discovery	2.5	2.5	2.5	2.5	2.5
C Integration	3.5	3	3.5	3.5	3
A Change	2	2.5	2	2	2
Homework	2.5	2.5	2.5	2.5	2.5
Total	32.5	33	32.5	33	32.5

3/11 “P”	KS	JH	MR	RL	PB
Agenda	3.5	3	2.5	3	3
Feedback	4	4	4	4	4
Collaboration	4	4	4	4.5	4
Pacing	4	4	4	4	3.5
I P Effectiveness	4	4	5	4.5	4
Emotions	3.5	3.5	3.5	3.5	4
Cognitions	3	3	3	3	3
Behaviours	3.5	3	3.5	3	3
G Discovery	3.5	3.5	3.5	3.5	3.5
C Integration	4	3.5	3.5	3.5	3.5
A Change	3	3	3	3	3
Homework	3.5	3	3	3	3.5
Total	44	41.5	42.5	42.5	42

11/12 “S”	KS	RA	MR	RL	PB
Agenda	3	3	3.5	3	3
Feedback	3.5	3.5	3.5	3	3.5
Collaboration	4	4	3.5	3.5	4
Pacing	3	3	2.5	3	3.5
I P Effectiveness	4	4	4	4.5	4
Emotions	3.5	3	3.5	3	3.5
Cognitions	3	3	3	3	3
Behaviours	3.5	4	3	4	3.5
G Discovery	3	3	3	3.5	3
C Integration	4	4	4	4	3.5
A Change	3.5	3	3	3.5	3.5
Homework	2	2.5	2	2.5	2
Total	40	40	38.5	40	40

3/13 “A”	KS	JH	MR	RL	PB
Agenda	2	2	2	2.5	2
Feedback	3	3	3.5	2.5	3
Collaboration	2.5	3	3	2.5	3
Pacing	2.5	2	2.5	2.5	2.5
I P Effectiveness	3	3	3	3	3
Emotions	2.5	3	2.5	2.5	3
Cognitions	2.5	3	3	3	3
Behaviours	2	2	2	2.5	2
G Discovery	2.5	2.5	3	2.5	3
C Integration	3.5	3	3.5	3.5	3
A Change	2	2	2	2.5	2
Homework	2	1.5	2	1.5	2
Total	30	30	32	31	31.5

Appendix 5: Consent form and Participant Information Sheet for Parts 1 and 2 of the research

Participant Information Sheet (Version 1)

My name is Matthew Wilcockson and I am a Cognitive Behavioural Therapist in Coventry and Warwickshire Partnership Trust and a PhD student at the University of Coventry.

Study Title

The contribution of the core professions to the IAPT High Intensity Role**.**

Purpose of the Study

I am conducting a research study into the effects different core professions have on the beliefs and practice of your current role as a High Intensity Therapist, especially in the context of what practice is absorbed from the IAPT training and what culture and practice is retained from the core profession or previous role.

The research is divided into 2 parts, which you can consent for individually – you may consent for one part but not the other:

Part A: In this part I am assessing comparing CBT skills on admission to the course by comparing the first submitted CTS-r's across different core professions. Here, you are consenting to allowing the researcher to use your (anonymised) first CTS-r, both student and supervisor ratings.

Part B: In this part I am comparing the themes emerging from undertaking the course across the different core professions, using the reflective journal as a data source. Here, you are consenting to the use of your learning journals, anonymised as below.

Why have I been chosen?

You have been chosen to participate alongside all other high intensity therapists undertaking the as your opinion concerning your current practice of CBT, particularly in the context of the study purpose above, is valuable to understanding how the High Intensity Role, assumed to be homogenous by the NHS is approached and practiced by different groups.

Do I have to take part?

Your participation in this study is completely voluntary and anonymous and undertaken in line with NMC and BABCP codes of conduct, and Coventry University and NHS Guidelines.

What will happen to me if I take part?

You will be asked to take part in a focus group with other members of a similar professional background to discuss issues of current and historical practice and identity. Based on the focus group, the interviewer may request an individual meeting with you to clarify issues raised in the interview.

What are the possible disadvantages and risks of taking part?

There are unlikely to be any disadvantages or risks of taking part. However, taking part in the study is not a requirement of your job role and there will be no negative consequences to you if you do not wish to complete the study.

Appendix 6 – Consent form and Participant Information Sheet for part 3 of the research.

Participant Information Sheet (Version 2)

My name is Matthew Wilcockson and I am a Cognitive Behavioural Therapist in the NHS, and also a PhD student at the University of Coventry.

Study Title

The contribution of the core professions to the IAPT High Intensity Role**.**

Purpose of the Study

I am conducting a research study to explore issues presenting for High Intensity Therapists from different core professional backgrounds. I am particularly interested in what practice is absorbed from the IAPT training and what culture and practice is retained from the core profession or previous role.

Why have I been chosen?

You have been chosen to participate alongside all other high intensity therapists in Coventry and Warwickshire Partnership Trust as your perspectives on the above issues are valuable to the research being conducted.

Do I have to take part?

Your participation in this study is completely voluntary and anonymous and undertaken in line with NMC and BABCP codes of conduct, and Coventry University and NHS Guidelines.

What will happen to me if I take part?

You will be asked to take part in a focus group with other members of a similar professional background to discuss issues of current and historical practice and identity. Based on the focus group, the interviewer may request an individual meeting with you to clarify issues raised in the interview.

What are the possible disadvantages and risks of taking part?

There are unlikely to be any disadvantages or risks of taking part. However, taking part in the study is not a requirement of your job role and there will be no negative consequences to you if you do not wish to complete the study.

What are the benefits?

There are no immediate personal benefits to you; however, by taking part you will provide valuable information which will help in the research of this topic area, and may inform future teaching practice on the IAPT diploma course to help overcome issues of learning specifically related to your previous role, and as such, benefit future intakes. The researcher will send a brief communication of the findings to you when the study is completed

What if something goes wrong?

In the unlikely event that something does go wrong, Coventry University has indemnity insurance and you can contact the Chair of the Ethics Committee. Debriefing can be provided by the researcher who is a trained de-briefer, or by the COPE service, which provides debriefing ad/or therapy to employees of Coventry and Warwickshire Partnership Trust.

Will my taking part in this study be kept confidential?

You do not have to take part in this study, however if you do choose to participate, all information taken outside the room will be anonymised. All focus group recordings will be stored according to Coventry University policies. The audio data will be deleted / destroyed at the end of the study

What will happen to the results of the research study?

The results will be used to inform my PhD research and will be written up as part of my thesis.

A summary of the findings will also be passed to your organisation at the end of the project and will be distributed in the most appropriate way.

Who is organising the funding of the research?

The research is funded by the researcher.

Who has reviewed the study?

The study has been reviewed and approved by Coventry University Ethics Committee.

Contact for further information

If you do have any questions please contact me at the following email address wilcock3@uni.coventry .co.uk.

Complaints

If at any point you have any complaints about the conduct of any aspect of this research, please feel free to contact Professor Ian Marshall, who is independent of the research team and who is responsible for overseeing research reviewed by the Coventry University Ethics Committee. Professor Marshall's contact details are below.

Professor Ian Marshall

Chair of Coventry University Ethics Committee

AB125

Coventry University

Priory Street

Coventry

CV1 5FB

Phone: 024 7679 5293

E-mail: I.Marshall@coventry.ac.uk

If you are happy to complete the study, please read the participant information sheet carefully and then you will be contacted by the researcher to arrange a date for the focus group to occur.

Informed Consent Form

Title of Project: The contribution of the core professions to the IAPT High intensity role

Name of Researcher Matthew Wilcockson

and contact details Department of Clinical Psychology**,**

Coventry University

Faculty of Health and Life Sciences

Priory Street

Coventry

CV1 5FB

Email: wilcock3@coventry.ac.uk

Please initial box to affirm consent

1. I confirm that I understand the information provided to me (dated .....) for the above study and have had the opportunity to ask questions.

☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason

☐

3. I agree to the interview being audio-taped. ☐

4. I agree to take part in the above study. ☐

_____	_____	
Name of Participant	Date	Signature
_____	_____	
Name of Person taking consent (if different from researcher)	Date	Signature

Thank you very much for your time

Matthew Wilcockson.

Appendix 7

- **Coventry University Ethics phases 1 and 2**
- **Coventry University Ethics phase 3**
- **Letter from NRES confirming that ethics approval is not necessary for any part of the research.**

Ethics Phase 1

REGISTRY RESEARCH UNIT

ETHICS REVIEW FEEDBACK FORM

(Review feedback should be completed within 10 working days)

Name of applicant: Matthew Wilcockson.....

Faculty/School/Department: [Health and Life Sciences] HLS
Psychology .....

Research project title: The contribution of the different core professions to the IAPT High Intensity Role P5555

Comments by the reviewer

7. Evaluation of the ethics of the proposal: The study as described meets ethical and research governance requirements.	
8. Evaluation of the participant information sheet and consent form: The content of the participant information sheet and consent form are satisfactory, except that the participant information sheet requires a title on it, and both require a version number and date adding.	
9. Recommendation: (Please indicate as appropriate and advise on any conditions. If there any conditions, the applicant will be required to resubmit his/her application and this will be sent to the same reviewer).	
	Approved - no conditions attached
X	Approved with minor conditions (no need to re-submit)
	Conditional upon the following – please use additional sheets if necessary (please re-submit application)
	Rejected for the following reason(s) – please use other side if necessary

	Not required

Name of reviewer: Anonymous .....

Date: 31/08/2012 .....

REGISTRY RESEARCH UNIT

ETHICS REVIEW FEEDBACK FORM

(Review feedback should be completed within 10 working days)

Name of applicant: Matthew Wilcockson

Faculty/School/Department: [Faculty of Health and Life Sciences]
Psychology .....

Research project title: The Contribution of the Core Professions to the IAPT High Intensity Role
P9584

Comments by the reviewer

10. Evaluation of the ethics of the proposal:
11. Evaluation of the participant information sheet and consent form:
12. Recommendation: (Please indicate as appropriate and advise on any conditions. If there any conditions, the applicant will be required to resubmit his/her application and this will be sent to the same reviewer).

	Approved - no conditions attached
	Approved with minor conditions (no need to re-submit)
	Conditional upon the following – please use additional sheets if necessary (please re-submit application)
	Rejected for the following reason(s) – please use other side if necessary
X	Not required

Name of reviewer: Anonymous .....

Date: 19/07/2013 .....

Email confirming approval not necessary from NHS

From: Buttery Toby [Toby.Buttery@westmidlands.nhs.uk]
Sent: 09 January 2012 09:56
To: Wilcockson Matthew (RYG) C&W PARTNERSHIP TRUST
Subject: FW: Is approval needed here?

Dear Matt,

The Chair of a committee has net the following response to your enquiry:

"I agree that this does not require review under the NRES scheme and may be reviewed by the university's REC."

Kind Regards,

Toby

Mr Toby Buttery | NRES (REC) Assistant Co-ordinator (Temporary)
NRES Committee West Midlands - The Black Country
NRES Committee West Midlands - Staffordshire

Health Research Authority
National Research Ethics Service (NRES)
Telephone: 01527 582539 Fax: 01527 582540
West Midlands Research Ethics Committee Centre, Prospect House, Fishing Line Road, Enfield, Redditch B97 6EW

Email: toby.buttery@westmidlands.nhs.uk www.hra.nhs.uk
www.nres.nhs.uk

Appendix 8 – Box plots and confirmatory data for parametric assumptions

Part 1a

	Nursing			Counselling			KSA			OT		
	Normality	Skew	Kurtosis	Normality	Skew	Kurtosis	Normality	Skew	Kurtosis	Normality	Skew	Kurtosis
Agenda	Y*	N*	N*	Y*	Y	N*	Y*	N*	N*	N	N*	N*
Feedback	N	N*	N*	N	N*	N*	Y*	N*	N*	N	N*	N*
Collaboration	Y*	N*	N*	Y*	N*	N*	Y*	N*	N*	N	N*	N*
Pacing	Y*	N*	N*	Y*	N*	N*	N	N*	N*	N	N*	N*
Interpersonal	Y*	N*	N*	N	N*	N*	Y*	N*	N*	Y*	N*	N*
Emotions	Y*	N*	N*	Y*	N*	N*	Y*	N*	N*	N	N*	N*
Cognitions	Y*	N*	N*	N	N*	N*	Y*	N*	N*	N	N*	N*
Behaviours	Y*	N*	N*	Y*	N*	N*	Y*	N*	N*	N	N*	N*
G. Discovery	Y*	N*	N*	N	N*	N*	Y*	N*	N*	N	N*	N*
Integration	Y*	N*	N*	N	N*	N*	Y*	N*	N*	N	N*	N*
A. Change	N	N*	N*	N	N*	N*	Y*	N*	N*	Y*	N*	N*
Homework	Y*	N*	N*	Y	N*	N*	Y*	N*	N*	N	N*	N*
	10/12	12/12	12/12	5/12	11/12	12/12	11/12	12/12	12/12	2/12	12/12	12/12

Legend: * - indicative of normality

Reflective differences (Part 1b)

	Nursing			Counselling			KSA			OT		
	Normality	Skew	Kurtosis	Normality	Skew	Kurtosis	Normality	Skew	Kurtosis	Normality	Skew	Kurtosis
Agenda	Y	N *	N *	N	N *	N *	Y	N *	N *	N	N *	N *
Feedback	Y	N *	N *	Y	N *	N *	Y	N *	N *	N	N *	N *
Collaboration	Y	N *	N *	Y	N *	N *	Y	N *	N *	N	N *	N *
Pacing	Y	N *	N *	Y	N *	N *	Y	N *	N *	Y	N *	N *
Interpersonal	Y	N *	N *	Y	N *	N *	Y	Y	Y	Y	N *	N *
Emotions	Y	N *	N *	Y	N *	N *	Y	N *	N *	Y	N *	N *
Cognitions	Y	N *	N *	Y	Y	Y	Y	Y	Y	N	N *	N *
Behaviours	Y	N *	N *	Y	N *	N *	Y	N *	N *	Y	Y	Y
G. DIscovery	Y	N *	N *	Y	Y	Y	Y	Y	Y	Y	Y	Y
Integration	Y	Y	Y	Y	N *	N *	Y	Y	Y	N	N *	N *
A. Change	Y	N *	N *	N *	N *	N *	Y	Y	Y	Y	Y	Y
Homework	Y	N *	N *	Y	N *	N *	Y	N *	N *	N	N *	N *
	0/12	11/12	11/12	10/12	10/12	10/12	12/12	7/12	7/12	6/12	9/12	9/12

Appendix 9: Normality data 1b

Reflective differences normality information

		Kolmogorov-Smirnov[a]			Shapiro-Wilk		
	Prof. Background	Statistic	df	Sig.	Statistic	df	Sig.
Agenda setting	RMN	.226	27	.001	.888	27	.007
	Counselling	.177	16	.193	.901	16	.084
	KSA	.200	27	.007	.892	27	.009
	OT	.241	6	.200*	.913	6	.456
Feedback	RMN	.227	27	.001	.763	27	.000
	Counselling	.330	16	.000	.788	16	.002
	KSA	.313	27	.000	.826	27	.000
	OT	.214	6	.200*	.958	6	.804
Participation	RMN	.244	27	.000	.915	27	.029
	Counselling	.283	16	.001	.889	16	.054
	KSA	.315	27	.000	.846	27	.001
	OT	.492	6	.000	.496	6	.000
Collaboration	RMN	.177	27	.030	.916	27	.032
	Counselling	.343	16	.000	.827	16	.006
	KSA	.250	27	.000	.920	27	.040
	OT	.283	6	.143	.921	6	.514
Interpersonal effectiveness	RMN	.178	27	.028	.935	27	.092
	Counselling	.261	16	.005	.914	16	.133

	KSA	.331	27	.000	.587	27	.000
	OT	.333	6	.036	.814	6	.078
Emotions	RMN	.246	27	.000	.871	27	.003
	Counselling	.269	16	.003	.900	16	.079
	KSA	.290	27	.000	.868	27	.003
	OT	.392	6	.004	.701	6	.006
Cognition	RMN	.264	27	.000	.897	27	.011
	Counselling	.273	16	.002	.816	16	.004
	KSA	.412	27	.000	.701	27	.000
	OT	.283	6	.143	.921	6	.514
Behaviours	RMN	.308	27	.000	.847	27	.001
	Counselling	.298	16	.000	.846	16	.012
	KSA	.352	27	.000	.799	27	.000
	OT	.407	6	.002	.640	6	.001
Guided discovery	RMN	.208	27	.004	.831	27	.001
	Counselling	.439	16	.000	.655	16	.000
	KSA	.501	27	.000	.442	27	.000
	OT	.492	6	.000	.496	6	.000
Conceptual integration	RMN	.268	27	.000	.804	27	.000
	Counselling	.266	16	.004	.856	16	.017
	KSA	.329	27	.000	.760	27	.000
	OT	.302	6	.094	.775	6	.035
Application of change methods	RMN	.186	27	.018	.936	27	.098
	Counselling	.161	16	.200*	.941	16	.356
	KSA	.340	27	.000	.774	27	.000
	OT	.492	6	.000	.496	6	.000

Homework setting	RMN	.292	27	.000	.828	27	.000
	Counselling	.244	16	.012	.809	16	.004
	KSA	.218	27	.002	.931	27	.073
	OT	.285	6	.138	.831	6	.110

Appendix 10: Example extract from personal journal

12th March 2012 – Today I attended a one day workshop in Dynamic Interpersonal therapy (DIT). There was an almost even split of counsellors and CBT therapists within the group. Of course, you are more likely to notice what you are interested in, but the difference was palpable. There was a degree of angry resentment towards CBT, especially in the context of "dumbing down" therapy, and a national preference for therapies in line with management agendas. It is certainly the case that colleagues have strong reactions in groups and when placed under threat / asked to defend themselves. Will this produce a difference between phases 2 and 3 of the research, with individual and group collection data methods respectively? There was also a reinforcing, but also an attempt at "ownership" of the core conditions (empathy, genuineness and unconditional positive regard) from some of the stronger counsellors.

Appendix 11: Initial notes extract from learning journal, and a sample of substantive coding

The Cognitive Therapy Scale-revised (CTS-R) was initially a tool which I approached with no small amount of trepidation. Here was a scale which rates my effectiveness as a clinician; all previous validation pertaining to my clinical practice had been anecdotal and qualitative, and I believed that I was an effective practitioner, due to the receipt of largely positive feedback over the years. The application of a specific tool to test specific skills in specific areas was new to me, and I initially did not believe that my practice would alter in any way based around yet another CBT rating scale, as I believed that I would score highly in each area automatically, due to my previous clinical experience.

My first of six completed self rated scales proved to be somewhat of a rude awakening, and I quickly realised that my clinical style, possibly Interpersonal Effectiveness aside, was simply "not CBT" enough. This initial scale immediately identified key areas in which I needed to focus, particularly Agenda Setting, which I scored a 0 on my first scale, having not set an agenda at all. Fortunately this was a relatively straightforward issue to resolve, but I remain relatively weak in this area, as I continue to tend to allow the session to flow naturally, rather than it being structured around a set time frame.

A further area which the CTS-R identified that was deficient was my use of Guided Discovery. This is a concept which I had rarely employed in previous roles, as many of the patients I would be dealing with were too acutely ill to work appropriately within this framework. I saw my role as one who could facilitate a solution to a problem, often providing potential solutions directly. I have devoted a great deal of time in refining my skills in this area, and the marked increase in my CTS-R scores as my experience grew reflects this.

The area which has remained most static within the CTS-R has been "Interpersonal Effectiveness". This is an area in which I am particularly comfortable as a clinician, and I do consider myself to be proficient in this area. Indeed, developing and maintaining a strong therapeutic alliance has assisted me on occasions where maybe my awareness and knowledge of CBT process has not been as it should. I strongly believe that a strong alliance is inherently therapeutic in itself, and I now feel that I may have rather "hid" behind my skills in this area during early sessions. The completion of subsequent CTS-R's highlighted this.

7

N/001/6.7-10 Being encouraged to talk about clinical work from a personal perspective is alien

N/001/6.10-11 Being open about feelings was initially difficult.

N/001/6.11 Feelings previously swept away

N/001/6.13-14 At start, learning journal perceived as waste of time by student – focusing on problems in the past.

N/001/6.15-17 – Student experienced resistance to completing learning journal.

N/001/6.17-20 Student accepted having to complete a learning journal – but only because this was enforced initially.

N/001/6.21-22 Challenges in practice led to learning journal being beneficial

N/001/6.23-24 Appreciation in reflecting on situations / self "as is"

N/001/6.24-25 Alternative to learning journals is to edit by being "professional", or risk upsetting people

N/001/6.26-28 Reflection becoming internalised as a personal and experiential process

N/001/6.29-30 Reflection on 5.1-3 – forgetting past problems not the best strategy

N/001/7.2-3 Never previously objectively rated as a clinician

N/001/7.3-5 Believed was good clinician because of positive (anecdotal, qualitative) feedback and well respected clinically

N/001/7.6-9 Confident that practice was already good enough because he was experienced practitioner – plan to "cruise through"

N/001/7.9-11 Rude awakening – not "CBT enough" on first CTS-r – needs adjustment in practice

N/001/7.11-13 Scored 0 on Agenda setting – not a natural way of practicing for the clinician – wanted to be less formal

N/001/7.18-19 – Secondary and complex care clients not appropriate for guided discovery

N/001/7.19-20 – Instead of guided discovery, focused on direct problem solving – pride in this previously

N/001/7.20-21 Dissonance in what was required prompted skills refinement, leading to improvement.

N/001/7.18-21 Interpersonal effectiveness "Familiar and safe territory" something to fall back on when lacking CBT skills initially

N/001/7.26-29 – "Hid" behind alliance skills in early sessions

Appendix 12: Interview Schedule and Protocol

The Interview will be semi-structured in nature, based on the questions below:

These questions were amended slightly following a pilot interview review following a pilot interview.

- What attitudes and practice from your previous roles remain important to you now?

Follow-up: Do any of these conflict with your current role?

- What attitudes and practice has changed from your previous role?
- As a group, what attitudes and aspects of practice do you feel you have in common now?
- How do your attitudes, values and practice compare with others in the same current role?
- Has your previous role helped carry out your current one in any way? Has it hindered in any way?

Smith's (1995) protocol for semi-structured interviewing – an extract:

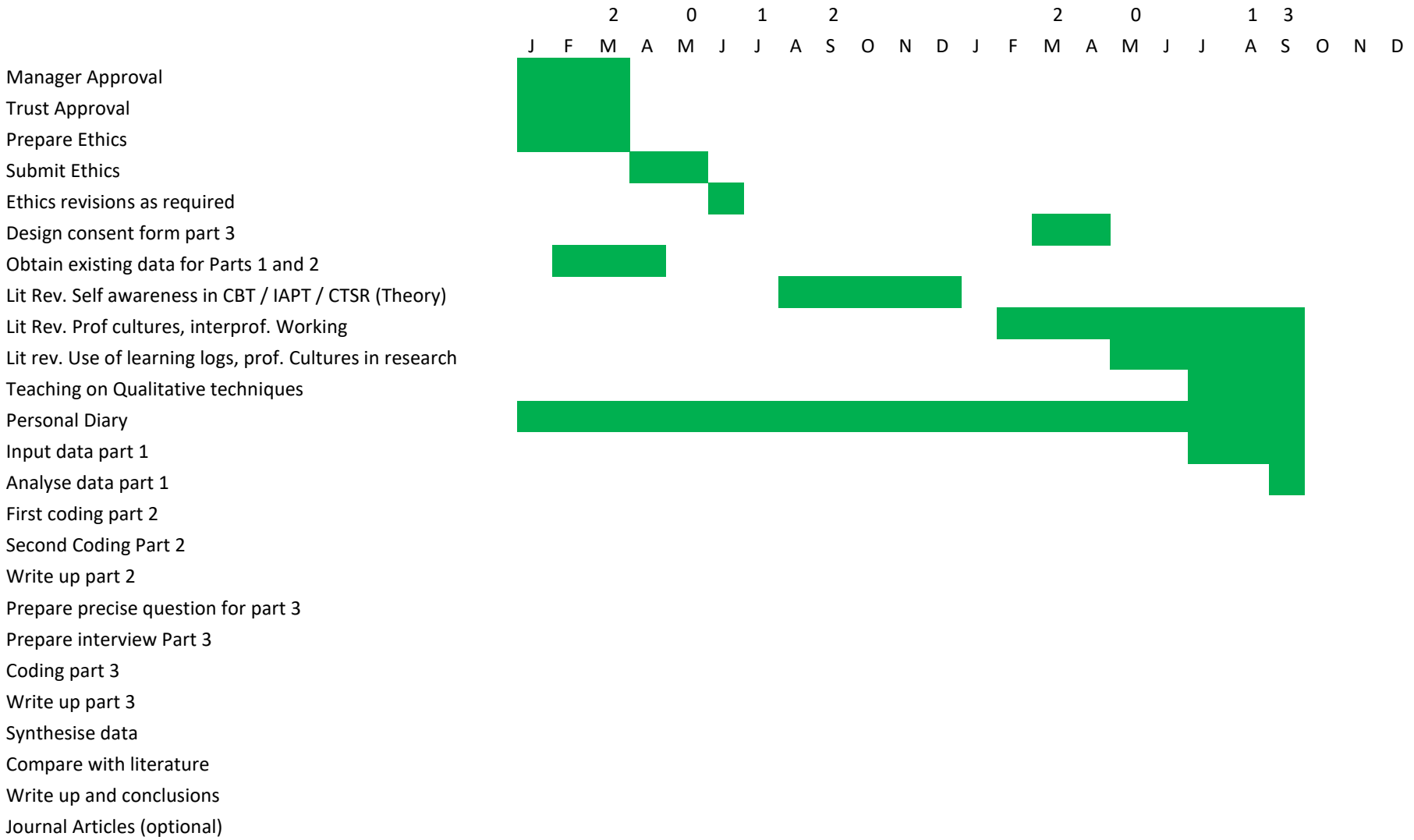
'With semi structured interviews, the investigator will have a set of interview questions or an interview schedule but the interview will be guided by the schedule rather than be dictated by it. Here then: [compared with structured interviews]

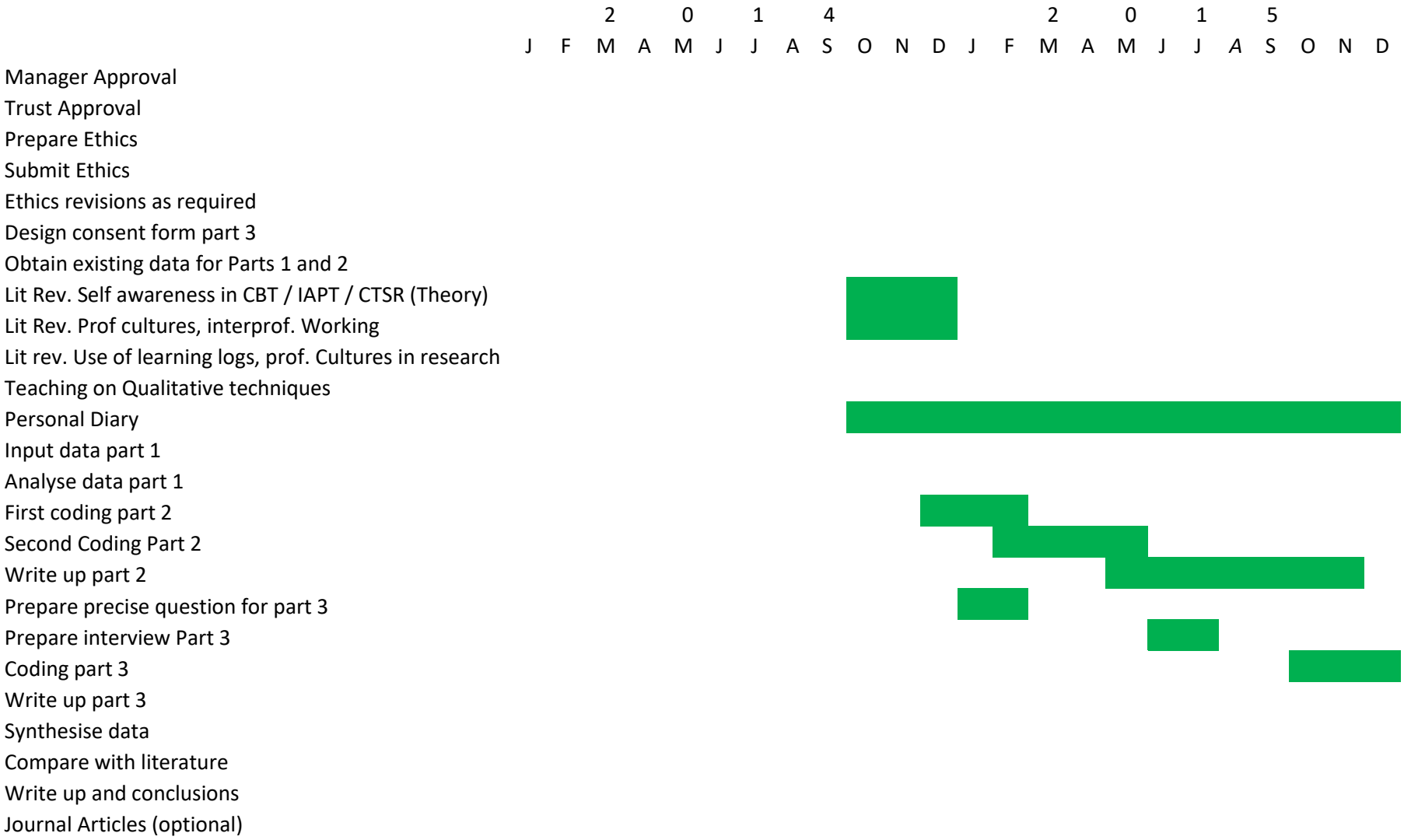
1. There is an attempt to establish rapport with the respondent.
2. The ordering of questions is less important
3. The interviewer is freer to probe interesting areas that arise
4. The interviewer can follow the respondents interests or concerns'

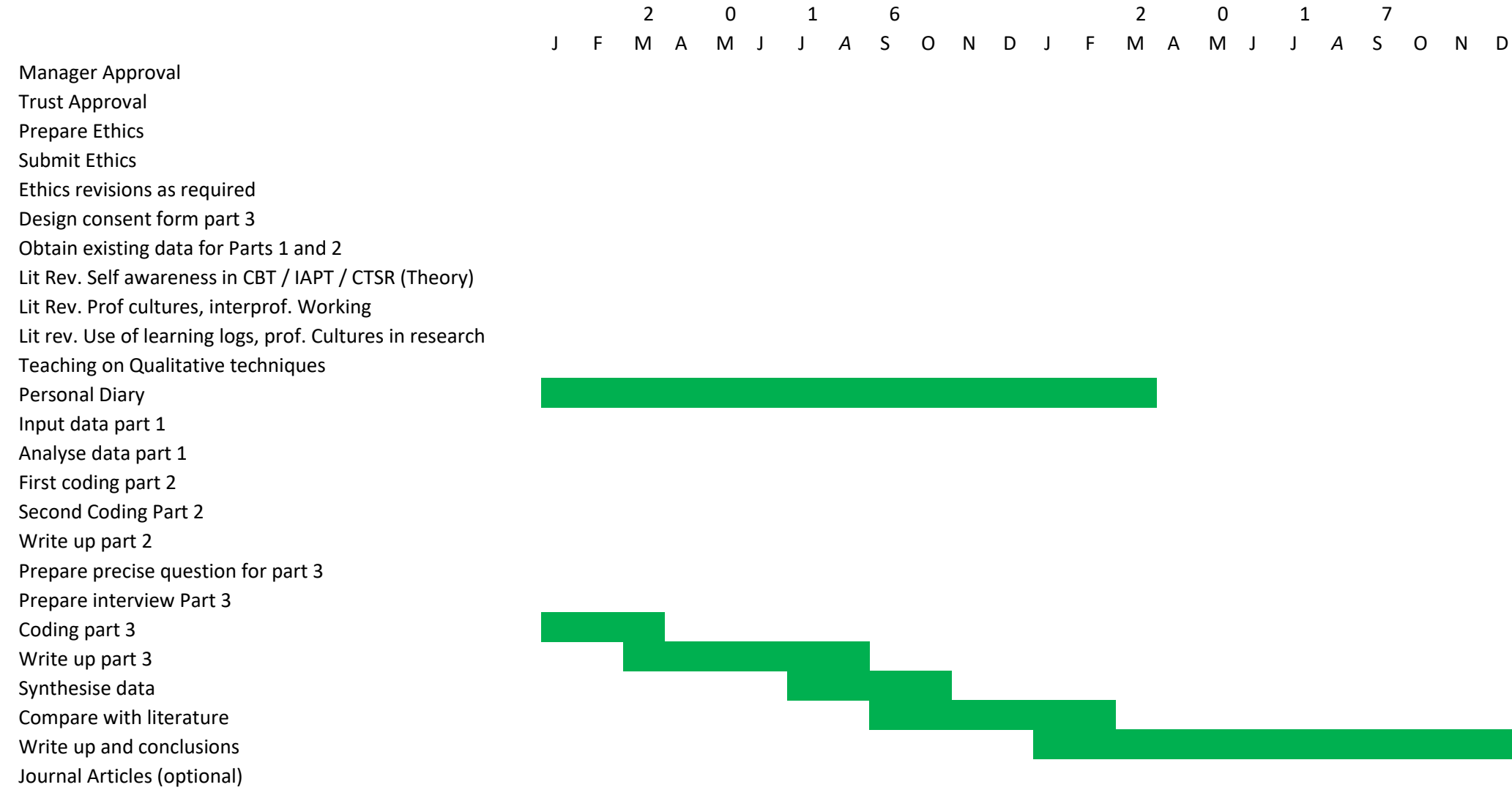
Appendix 13, Timeline of research.

Below is a GANTT chart summarising the timeline of the research phases

Note that there was a break in my study between September 2013 and September 2014


2012
2013
J F M A M J J A S O N D J F M A M J J A S O N D
Manager Approval
Trust Approval
Prepare Ethics
Submit Ethics
Ethics revisions as required
Design consent form part 3
Obtain existing data for Parts 1 and 2
Lit Rev. Self awareness in CBT / IAPT / CTSR (Theory)
Lit Rev. Prof cultures, interprof. Working
Lit rev. Use of learning logs, prof. Cultures in research
Teaching on Qualitative techniques
Personal Diary
Input data part 1
Analyse data part 1
First coding part 2
Second Coding Part 2
Write up part 2
Prepare precise question for part 3
Prepare interview Part 3
Coding part 3
Write up part 3
Synthesise data
Compare with literature
Write up and conclusions
Journal Articles (optional)


2014 2015
J F M A M J J A S O N D J F M A M J J A S O N D
Manager Approval
Trust Approval
Prepare Ethics
Submit Ethics
Ethics revisions as required
Design consent form part 3
Obtain existing data for Parts 1 and 2
Lit Rev. Self awareness in CBT / IAPT / CTSR (Theory)
Lit Rev. Prof cultures, interprof. Working
Lit rev. Use of learning logs, prof. Cultures in research
Teaching on Qualitative techniques
Personal Diary
Input data part 1
Analyse data part 1
First coding part 2
Second Coding Part 2
Write up part 2
Prepare precise question for part 3
Prepare interview Part 3
Coding part 3
Write up part 3
Synthesise data
Compare with literature
Write up and conclusions
Journal Articles (optional)


2016
2017
J F M A M J J A S O N D J F M A M J J A S O N D
Manager Approval
Trust Approval
Prepare Ethics
Submit Ethics
Ethics revisions as required
Design consent form part 3
Obtain existing data for Parts 1 and 2
Lit Rev. Self awareness in CBT / IAPT / CTSR (Theory)
Lit Rev. Prof cultures, interprof. Working
Lit rev. Use of learning logs, prof. Cultures in research
Teaching on Qualitative techniques
Personal Diary
Input data part 1
Analyse data part 1
First coding part 2
Second Coding Part 2
Write up part 2
Prepare precise question for part 3
Prepare interview Part 3
Coding part 3
Write up part 3
Synthesise data
Compare with literature
Write up and conclusions
Journal Articles (optional)